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ROYAL COMMISSION ON HEALTH SERVICES

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ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the hearing at St. John's, Thursday, November 2nd, 1961

COMMISSION MEMBERS:

Chief Justice EMMETT H. HALL -- Chairman

Miss ALICE GIRARD, R.N.

Mr. DAVID M. BALTZAN

Prof. O.J. FIRESTONE

Mr. M. WALLACE McCUTCHEON, Q.C.

Dr. C.L. STRACHAN

Dr. ARTHUR F. VAN WART

COMMISSION COUNSEL:

Mr. R.N. HALL, Q.C.

MEDICAL CONSULTANT:

Dr. PIERRE JOBIN

DIRECTOR OF RESEARCH:

Prof. BERNARD BLISHEN

SECRETARY:

Maj. N. LAFRANCE

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St. John's, Newfoundland,
Thursday, November 2nd, 1961.

--- On resuming at 9.30 a.m.

THE CHAIRMAN: Mr. Minister, ladies and gentlemen, we are now ready to open the hearings of the Royal Commission on Health Services for the public hearings in the Province of Newfoundland.

SUBMISSION OF THE DEPARTMENT OF HEALTH OF THE PROVINCE OF NEWFOUNDLAND

Appearances: The Hon. Dr. James M. McGrath, Minister of Health
Dr. Leonard A. Miller, B.A., M.D., C.M., M.P.H., Deputy Minister of Health

HON. DR. McGRATH: As Minister of Health for Newfoundland, and representing the Newfoundland Government, I am very happy to welcome yourself and your colleagues here this morning, and of course we are all happy that out of these discussions, both here and elsewhere, will come importance repercussions on the health of the people of Canada, and the means by which we hope to advance it.

Dr. Miller will present our short submission in a moment.

The senior officers of the Department of Health are here in case you wish to consult any of them, and also the senior officers of some of the other departments, ancillary, more or less, which impinge on this problem, and the Deputy Minister of Health and Welfare is here, and the Chairman of the Workmen's Compensation Board, and I think you will agree it is a representative gathering, and any information you may desire to have will be presented immediately or obtained for you.

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I am sure I don't need to remind you that all the resources of the Department are at your service. I will now ask Dr. Miller to present our submission.

THE CHAIRMAN: Before you begin, I would like to thank Dr. McGrath for his welcome, and I know we will have your co-operation, because Dr. McGrath offered it some time ago, and it is very gratefully received.

DR.MILLER: As Dr. McGrath stated, I just propose to read the conclusions and recommendations.

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THE CHAIRMAN: Before you begin, I would like to [illegible] it is very gratefully received.

DR.MILLER: As Dr. McGrath stated, I just propose to read the conclusions and recommendations.

SUMMARY OF CONTENTS

(1) Brief description of Newfoundland with some basi health statistics.

(2) Special features of Newfoundland Department of Health.

(3) Description of facilities with personnel details.

(4) Provision of personal health services with special reference to -

(a) Cottage Hospital Medical Care Plan

(b) Children's Health Services

(c) Hospital Insurance

(d) Indigents

(5) Miscellaneous -

(a) Federal-Provincial relations in the health field.

(b) Provincial plan of assistance to medical and dental students.

(6) Conclusions and recommendations -

(a) It is difficult for Newfoundland, from her own resources, to provide an adequate personal health service, including prevention, diagnosis, treatment and rehabilitation.

IT IS RECOMMENDED THAT consideration be given to a plan of special financial assistance from the Government of Canada to the province, which would take into account existing deficiencies and needs in health and hospital services.

(3) Description of facilities with personnel details.

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(b) Children's Health Services

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(c) In spite of the more rapid improvement in personnel and facilities since 1949, the situation in Newfoundland still compares very unfavourably, on a population basis, with the rest of Canada. IT IS RECOMMENDED THAT the Commission investigate the lengthening periods of training now being required for most categories of health personnel in Canada to determine if it is possible to reduce the length of training courses without lowering the quality of the finished product of such training courses.

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(e) In spite of the more rapid improvement in personnel and facilities since 1949, the situation in Newfoundland still compares very unfavourably, on a population basis, with the rest of Canada. IT IS RECOMMENDED THAT the Commission investigate the lengthening periods of training now being required for those categories of health personnel in Canada to determine if it is possible to reduce the length of training courses without lowering the quality of the finished product of such training courses.

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gaps in coverage.

IT IS RECOMMENDED THAT -

(I) Consideration be given to the increasing of Hospital Construction Grants to a more realistic level.

(II) Consideration be given to a widening of the scope of hospital insurance payments to include the cost of hospitalization of mentally ill and tuberculous patients and a larger component of capital cost.

(e) The Department of Health of Newfoundland is already deeply involved in the provision of personal health services.

IT IS RECOMMENDED THAT any proposed expansion in the provision of personal health services be included within the scope of the Department of Health, thus avoiding unnecessary duplication through the establishment of separate organizations to deal with individual aspects of the provision of health services.

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1. Newfoundland, the most easterly province of Canada, has an area of 156,185 square miles, of which 42,734 square miles are contained in the rougly triangular island. The remaining area is made up by Newfoundland Labrador. While the coastal areas are largely rugged and rocky, there is good agricultural land in the river valleys and in certain other areas. There are vast productive forest areas and also present, particularly in Labrador, is a large available, but yet unutilized source of water power. The main industries of the province are pulp and paper, fishing and mining.

2. Newfoundland's population of 470,000 is mostly rural. There are only two incorporated cities, St. John's on the eastern tip of the island with a population of about 62,000 (metropolitan area 86, 000) and Corner Brook on the west coast with a population of about 25,000. Over 70% of the total population lives in small towns and villages many of which are on the long and much indented coastline. Vast sections of the interior of the province are uninhabited. In spite of rapid improvements, both transportation and communications are still much less adequate than elsewhere in Canada. 50% of the population of Newfoundland is under twenty (Canada 42%). The birth rate for 1959 was 33.0 (Canada 8.0) per 1,000 population. The infant mortality rate was 39.0 per 1,000 live births (Canada 28) and the maternal mortality rate was .8 per 1,000 live births (Canada 0.5).

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3. The provincial budget for the fiscal year 1961-62 was over $87,000,000. Total expenditure by the Department of Health for health and hospital services is estimated at $17,300,000.

4. For 1960 the infant mortality rate for Newfoundland was 37 per 1,000 live births (compared with 57.8 for 1950 and 91.0 for 1940). The maternal mortality rate for 1960 was 21 (compared with 27 for 1950 and 38 for 1940). The death rate from all forms of Tuberculosis for 1960 was 9 per 100,000 of population (compared with 70 in 1950 and 172 in 1940). The tuberculosis death rate for all Canada for 1960 was 4.6. In spite of this remarkable reduction, the rates in all cases are still the highest in Canada.

5. The Newfoundland Department of Health has a long history of involvement in the provision of medical care and in the operation of hospitals. Some 120 of the 295 phusicians registered in the province hold salaried posts with the department. Of the remainder, practically all perform professional service on behalf of the department, either on a retainer or a fee-for-service arrangement. With a minimum of full-time medical personnel in public health, the aim of the department has been to accomplish as much preventive work as possible through the utilization of the services of physicians who are also providing medical care.

6. The tardy municipal development in Newfoundland has resulted in a practically complete absence of

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6. The tardy municipal development in Newfoundland has resulted in a practically complete absence of

financial responsibility by the municipalities for any type of health or hospital care. Many towns organized in recent years have had so many basic problems that they have still been unable to contribute financially to health services.

HOSPITAL BEDS

7. With 1880 general hospital beds, the province has but 4 beds per 1,000 of population. This is the lowest in Canada and just half of the number to be found in that province having the highest ratio of beds. The population of Newfoundland is increasing by at least 12,000 per year and it is estimated that an additional 1600 beds will be needed by 1968. This proposed figure, in addition to allowing for increased population, would also overcome some of the present deficit in beds and for a replacement of facilities already obsolete. Even this addition will give the province only 5.5 beds per 1,000 of the estimated population. Many authorities may consider this figure too low.

8. The situation with reference to beds for the mentally ill is even less satisfactory with a present capacity of less than two beds per 1,000 of population. Taking into consideration the same factors as outlined in the immediately preceeding paragraph, it is estimated that 1200 more beds will be needed by 1968. These figures indicate a total minimum additional bed requirement of 2800 beds by 1968. At a minimum average cost of $15,000 per bed, this constitutes a capital expenditure of at

least $44,000,000.

9. It should be noted that there are 500 general hospital beds under construction at present. Approximately two-thirds of all hospital beds in Newfoundland are owned and operated by the provincial government.

10 What has been said of hospital beds is equally true of out-patient facilities. This is particularly true with reference to community clinics for the diagnosis and treatment of the mentally ill, which do not now exist in the province.

PERSONNEL

11 In every category of professional personnel Newfoundland figures are lower than those of any other province of Canada. A total of 295 doctors in Newfoundland includes approximately 50 who are full-time with the Department of Health or in the larger institutions. If all the physicians registered are included, the ratio works out to approximately one doctor to over 1600 of the population but outside the larger centers there are many instances where an individual physician is serving from 3500 to 6500 people. The ratio in Canada as a whole is one physician to about 875 people.

12 The total number of dentists in Newfoundland is but 44 or one to about every 11,000 people (Canada one to 3,000). The figure for graduate nurses shows a total of 937 or 2.1 per 1,000 of population, (Canada 4.0 per 1,000).

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In every category of professional workers Newfoundland figures are lower than those in the other provinces of Canada. A total of 5.5 [illegible] in Newfoundland includes approximately 50 who are full-time with the Department of Health or in the larger institutions. If all the physicians registered are included, the ratio would be [illegible] approximately one doctor to every 1,000 of the population but outside the larger centres there are many instances where the individual physician is serving from 2,000 to 3,000 people. The ratio in Canada as a whole is one physician to [illegible] people.

12 The total number of dentists in Newfoundland is one dentist to every 11,000 people [illegible] nurses shows a total of 357 or 5.1 per 1,000 of population [illegible]

(With reference to paragraphs 1 to 12, see Appendix 1 - Annual Report of Newfoundland Department of Health, 1959).

13. COTTAGE HOSPITAL MEDICAL CARE PLAN

Estimating the population of the province at 470,000, 47% or 221,000 are eligible to join a prepaid health and hospital insurance plan sponsored and underwritten by the Government of the province. Of those eligible, 85% are paid up subscribers. Since the advent of Federal-Provincial Hospital Insurance, this plan covers domiciliary, out-patient and professional care in hospital. Instituted in 1935, this medical care plan is now available through eighteen hospitals with bed capacities ranging from 12 to 60. The only items not covered are transportation, drugs, dental care and obstetrics for which there is a nominal fee. With reference to drugs, where there are no commercial pharmacies in operation, drugs are supplied at cost through the cottage hospitals. Patients referred by their local Medical Officers are treated in the larger hospitals of the province with the Department of Health carrying the obligation for professional fees. The scale of fees is considerably lower than the accepted schedule of the Newfoundland Medical Association. (See Appendix 2)

13 CHILDREN'S HEALTH SERVICE

In 1956 legislation was passed whereby all medical and hospital services to children under

Report of Education Department of

MEDICAL ASSISTANCE [illegible]

Estimating the population of the province at 470,000, 44% or 221,000 are eligible to join a prepaid health and hospital insurance plan [illegible] and underwritten by the Government of Quebec. Of these eligible, 85% are paid up subscribers. Since the advent of Medical-Provincial Hospital [illegible]

[illegible] nation and professional care in hospitals. Introduced in [illegible], this medical care plan is now available through eight or nine hospitals with non-specialist staffing from 12 to 60. The only items not covered are transportation costs, dentures and cosmetics for which there is a [illegible] fee. With reference to drugs, where there are no commercial pharmacies in operation, drugs are supplied at cost through the cottage hospitals. Patients referred by their local Medical Officer are treated in the large hospitals or the [illegible] with the Department of Health assuming the contribution for professional fees. The scale of fees is considerably lower than the average schedule of the Montreal and Ottawa Associations. (See Appendix 2)

sixteen would be the obligation of the Provincial Government. The first step of this plan became operative on January 1st, 1957, covering hospital care and out-patient diagnostic facilities for this group of the population. Arrangements were made with all hospitals in Newfoundland whereby hospital rates were paid at ward level and diagnostic tests at agreed rates. Starting February 1st, 1958, the next step of this plan was taken whereby all patients under sixteen admitted to hospital with costs of their professional care becoming the responsibility of the Government. Agreement had been reached with the Newfoundland Division of the Canadian Medical Association to pay at the rate of 80% of the then existing local schedule of fees. Agreement was also reached on a sliding scale of payments to cover patients in hospital longer than thirty days. Agreement was also reached on a ceiling in remuneration of certain specialists. (See Appendix 3)

14 HOSPITAL INSURANCE

An agreement was signed with the Government of Canada so that Federal-Provincial Hospital Insurance became operative in Newfoundland on July 1st, 1953. The Newfoundland plan covered all in-patient services at ward level and a wide range of diagnostic services for out-patients. The hospital and diagnostic out-patient components of the Children's Health Plan were absorbed under Hospital Insurance. At present the reimbursement from the Government of Canada is at the rate of 63%. (See Appendix 4).

[illegible]

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15 INDIGENTS

The Newfoundland Department of Health has, for many years, been responsible for the medical care of indigents. This is done on the basis of a means test and physicians' services are remunerated either on a retainer or on a low fee-for-service arrangement. Similarly, all patients properly certified by the Department of Public Welfare are provided with free drugs through retail pharmacies, cottage hospitals or the Central Pharmacy operated by the Department of Health.

16 FEDERAL-PROVINCIAL RELATIONS IN THE HEALTH FIELD

This province has no criticism of the day-to-day relationships between the Department of National Health and the Provincial Department. The benefits of earmarked money in this connection are appreciated but the vary nature of the Orders-in-Council create what is considered to be an excessive amount of paper work in that every project has to be forwarded and approved on an individual basis. Rulings covering the fiscal side of the relationships are sometimes made on a one-sided basis and restrictions are added without the opportunity for consultation.

17 The Commission will, undoubtedly, have access to the total financial assistance available through the Federal-Provincial Health Grant arrangement. To the province of Newfoundland in the fiscal year 1961-62, the total available under seven separate headings was approximately $1,100,000, with an additional $2,000,000 available under the Hospital

The Newfoundland Department of Health has, for many years, been responsible for the medical care [illegible] citizens' services are concerned [illegible] on a pensioner or on a low fee-for-service basis. [illegible] by the Department of Public Welfare are provided with [illegible] through total guarantees, either hospitals or the federal Pensioner operated by the Department of Health.

[illegible] DAY-TO-DAY TOWN IN THE PROVINCE [illegible]

This province has no clear idea of the day-to-day relationships between the Government of Canada, Health and the provincial Department. The [illegible] of associated money in this connection are specifically not the very nature of the [illegible] which is considered to be an academic [illegible] of paper work [illegible] to be [illegible] and approved on a individual basis. In following, the French side of the [illegible] are sometimes made on a [illegible]-based basis [illegible] are added without the opportunity for [illegible]. The Government [illegible], moreover, has [illegible] to the total [illegible] available [illegible] the Federal-Provincial Health Grant arrangement. To the [illegible] of Newfoundland in the fiscal year [illegible] [illegible] $2,000,000 available under the hospital

Construction Grant. About 75% of 1.5 million of this latter figure is due to an accumulation of unused money. The other health grants are not accumulative and in most cases bear no relationship to the relative existing needs of the various provinces. Some of them, too, are matching grants and involve the expensiture of additional money from provincial sources.

18 These grants have been of inestimable benefit to the province of Newfoundland in providing for the training of all types of professional and ancillary personnel and the employment of such personnel in many branches of health services. It should be noted that the utilization of Health Grants has been somewhat limited since the institution of Hospital Insurance which means, in effect, that items which were previously covered completely under Health Grants are now covered only to the extent of the current percentage reimbursement under Hospital Insurance.

19 The amount of the contribution from the Government of Canada under the Hospital Construction Grant is limited to $2,000 per bed. At the present building costs, this rarely amounts to more than 20% of the total cost and in most cases to 15% or less. Under the Federal-Provincial agreement on Hospital Insurance, there is no coverage for hospitalization for the tuberculous or for the mentally ill and items of capital cost are excluded.

20 FINANCIAL ASSISTANCE TO MEDICAL AND DENTAL STUDENTS

In the absence of any Federal-provision for the under-graduate education of medical and dental students, Newfoundland has instituted a Provincial plan whereby an annual bursary of $1200 is made available to residents of Newfoundland during their professional courses. Students obligate themselves to return to Newfoundland to practise their professions. At present 32 medical and 6 dental students are being assisted under this plan. (See Appendices 5 and 6.)

21 Every effort has been made to limit the length of this presentation but additional information can be readily made available if the Commission so desires.

THE CHAIRMAN: Thank you, Dr. Miller. If you wish, and if you think it would be of any help to us, we would like you to comment on your brief and any part you would like to stress or bring our attention especially to. You are not limited to just reading those recommendations.

DR. MILLER: Sir, I don't think any useful purpose would be served by it at the moment, unless there are any questions.

COMMISSIONER STRACHAN: I was wondering how you count the success of your subsidization plan for medical and dental students. Are you satisfied with your subsidization plan for medical and dental students? Are there any pitfalls?

DR. McGRATH: To say that we are satisfied with it is a little bit early. We are only beginning now to get the benefits of it because, of course, it took five years before we had any people graduated. We are very satisfied with the plan. The only thing we wish is that it was wider in scope, but the number of medical students coming in under the plan is increasing, and we think it is a fine, practical and very useful plan, and that without it we would have lesser expectation than we have of the people to serve the country.

COMMISSIONER STRACHAN: You have no limits on the numbers?

DR.McGRATH: We have no limits. Unfortunately, they are only too limited. There is a built-in limit. We are hoping, and I cannot say it definitely, but we will examine the plan and see if we can improve it and

MR. CH. SWAN: Thank you, Dr. Miller. If [illegible] you would like to address or make any suggestions to, You are not limited to merely reading those recommendations.

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make it more useful to students and thereby attract more.

COMMISSIONER STRACHAN: Have you had any, for want of a better word, escapees?

DR. McGRATH: No, I think we have had a couple of cases, but I think there were extenuating circumstances. We think the boys recognize their moral obligation as well as the legal obligation.

COMMISSIONER STRACHAN: They are bound legally?

DR. McGRATH: They are bound to serve two years within the Health Department of the Province in any reasonable capacity to which the Minister directs them. At that point their legal and moral liability is satisfied, and if they remain in practice in Newfoundland for two years, the second two years of their subsidy is forgiven also. We felt that to tie a man down for two years was unrealistic.

COMMISSIONER STRACHAN: What is the average amount of your subsidy?

DR. McGRATH: $1,200 for the first four medical years, and in the fifth year a lesser amount, but up to $1,200 at the discretion of the Minister. As you know, men are getting married earlier these days, and a married man in the fifth year needs the subsidy, but a single man living in a hospital does not need the full amount.

COMMISSIONER STRACHAN: It is for five years?

DR. McGRATH: Yes.

COMMISSIONER STRACHAN: Can they buy themselves out?

[illegible]

[illegible]

[illegible]

DR. McGRATH: The second two years, yes. The first two years, no. It is explained to them very clearly at the time they take them that the first two years are a moral obligation as well as merely a legal one, but after the second two years they can free themselves of the obligation by repaying the subsidy, or practising in Newfoundland. They can repay that second two years without any stain, so to speak, on their integrity. They will have satisfied the obligation by the first two years of work with the Department.

COMMISSIONER STRACHAN: How are these monies paid to the students, personally or for tuition?

DR. McGRATH: They are paid personally, in two instalments. The student has to produce to us in August or September a certificate that he has been accepted by a recognized medical school, and he receives $600. At New Year, we request a report from the Dean of the Faculty of the University, saying he is in good standing, and then he gets his second $600. There are no strings on it at all.

COMMISSIONER STRACHAN: Are there any strings as to where he can take his course, anywhere in Canada?

DR. McGRATH: No, the only restriction is that it be a recognized medical school, which more or less limits it to the U.K., Canada and possibly the United States. We have quite a number in the old country, England and Ireland. The majority of them go to Dalhousie.

THE CHAIRMAN: How many of them have you at the moment?

DR. MILLER: 32.

COMMISSIONER BALTZAN: Dr. Miller, just

[illegible] a moral obligation as well as merely a legal one, [illegible] the second two years they can free themselves of [illegible] Newfoundland. They can repay that second two years without any strain, so to speak, on their integrity. They will [illegible] work with the Department.

COMMISSIONER STRACHAN: How are tuition fees paid to the students, personally or for tuition?

DR. McNAMATH: They are paid personally, in two instalments. The student has to produce to us in August or September a certificate that he has been accepted by a recognized medical school, and he receives $600. At New Year, we request a report from the Dean of the Faculty of the University, saying he is good standing, and then he gets his second $600. There are no strings on it at all.

COMMISSIONER STRACHAN: Are there any strings as to where he can take his course, anywhere in Canada?

DR. McNAMATH: No, the only restriction is that it be a recognized medical school, which more or less limits it to the U.K., Canada and possibly the United States. We have quite a number in the old country, England and Ireland. The majority of them go to Dalhousie.

THE CHAIRMAN: How many of them have you at

referring to your statement here: "In spite of this remarkable reduction", that is, the tuberculosis death rate for all Canada was 4.6, "--- the rates in all cases are still the highest in Canada". From a public health standpoint, knowing as we have known for a long time that fresh air is one of the best treatments, and I think you have wonderful air here, at least the air this morning is wonderful, where does that come in as far as this Province is concerned? Can you pinpoint that to any reason?

DR. McGRATH: The simple reason is that we started further back and at a much worse condition many years back. The height of the death rate some years ago was simply astonishing, and it simply is that we have not had time to catch up. I don't think there is any essential difference really between Newfoundland and the mainland as regards weather conditions. Housing conditions might, but I don't think they are any different than Quebec, for instance, but I think we had a much higher incidence of tuberculosis when it was much more difficult to control. In other words, we had a longer ladder to climb and take longer to get to the top.

COMMISSIONER BALTZAN: Yes, thank you. I think that is a very good reason for it. And you have one of the lowest representations of physicians per population, one to 1,600, is that true? It is approximately one doctor to over 1,600 of the population?

DR. MILLER: That is when you count all doctors in Newfoundland.

COMMISSIONER BALTZAN: All practising physicians?

[illegible] was H.G. "--- the rabies in all cases are [illegible] ignorant in Canada". From a public health standpoint, knowing as we have known for a long time that fresh air is one of the best preventives, and I think you have wonderful air here, at least the air this morning is wonderful, where does that come in as far as this Province is concerned? Can you pinpoint that to any reason?

DR. MACDERMOT: The simple reason is that we started further back and at a much worse condition many years back. The height of the death rate some years ago was simply astonishing, and it simply is that we have not had time to catch up. I don't think there is any essential difference really between Newfoundland and the mainland in regards weather conditions. Hunting conditions might, but I doesn't think they are any different than Quebec, for instance, but I think we had a much bigger incidence of tuberculosis when it was much more difficult to control. In other words, we had a longer ladder to climb and take longer to get to the top.

COMMISSIONER BARTZAN: Yes, thank you. I think that is a very good reason for it. And you have one one to 1,600, is that correct? It is approximately one doctor to over 1,600 of the population?

DR. MITCHEL: That is when you count all

DR. MILLER: No, all doctors, and I think it is noted there that there are some areas where there is one doctor to every 3,500 to 6,500. It is quite high in some places, and quite low in some places.

COMMISSIONER BALTZAN: Is that due to population density, or lack of concentration of population?

DR. MILLER: There are a number of reasons, but I think probably the basic reason is that we have to admit that a lot of these places are perhaps not the most desirable places to practise medicine. In other words, the people will not go to the isolated areas, and we have a larger percentage of isolated areas.

COMMISSIONER BALTZAN: Have you any sort of rapid transportation system like an air ambulance?

DR. MILLER: We have an air ambulance. We have two 'planes stationed in the northern part, one in Newfoundland and one in Labrador, and we have a contract with the local air service that we can fly out patients at any time, weather permitting, or fly personnel in.

COMMISSIONER BALTZAN: Is that working satisfactorily?

DR. MILLER: Yes, except that it is to some extent limited by weather conditions.

COMMISSIONER STRACHAN: What is your utilization, or planned utilization, of these medical and dental graduates?

DR. McGRATH: I think in a sense we would more or less play it by ear at the time. Our needs are so great, but say in a typical case of a young man who has qualified and is ready for service, we would put him in the

some places, and quite low in some places.

COMMISSIONER BOLLMAN: Is that due to [illegible]

[illegible]

[illegible]

Mr. I think probably the basic reason is that we have to admit that a lot of these places are perhaps not the most desirable places to practice medicine. In other words, the people is still not go to the isolated areas, and we have a larger percentage of isolated areas.

COMMISSIONER MACDANIEL: Have you any plan to [illegible]

Dr. [illegible]: We have an air ambulance. We have two planes stationed in the northern part, one in Newfoundland and one in Labrador, and we have a contract with the [illegible] so that we can fly out patients at any time, weather permitting, or fly personnel in.

COMMISSIONER MACDANIEL: Do they [illegible] radiate [illegible]

Dr. [illegible]: Yes, except that it is [illegible] account limited by weather conditions.

COMMISSIONER STRACHAN: Which is [illegible] plan, or planned activities, of these medical and dental [illegible]

Dr. [illegible]: I think in a sense [illegible] move or [illegible] play it by ear at the time. Our needs are [illegible]

area of greatest need.

What we are aiming at is that they should normally service the general hospital or one of the other general hospitals -- either the one in St. John's or one of the others -- for perhaps a year, and then a year in one of the isolated outposts. However, pressure may upset a plan of that kind, and it may be that we have such necessity in the outposts we might not be able to give a man a residency in a hospital. Essentially, the object is to provide service both for training in the larger hospitals and in the outposts, with the hope that some men might like the life out there and stay there, as some have done in the past, and spent quite a number of years there. We find, while it is hard to attract some to those areas, quite a proportion do like the life and stay. I can only quote myself as an example: I spent ten years there and quite enjoyed it.

COMMISSIONER STRACHAN: Have you any mobile clinics to look after the outposts?

DR. McGRATH: Yes, we have in Labrador what amounts to a mobile clinic by air, and we have six boats which operate in different parts of the coast and drop into various settlements. These are shore-based, of course, with the exception of one: we have one large boat, The Lady Anderson, which is on continual patrol in Placentia Bay, where no staff could operate with any efficiency at all. In that case the doctor lives aboard the boat. In the other cases the doctor lives on shore and his boat is ancillary to his practice, and he is able to take care of emergencies. Generally, with a severe emergency

reachable by 'plane we don't send the doctor out. We send a 'plane to bring the patient in -- sometimes to the major hospital in St. John's and sometimes to the nearest hospital to which they can be brought.

COMMISSIONER GIRARD: Mr. Chairman, I have no special question to ask, but I would like to make a note of commendation to the Minister of Health of this Province for the excellent nursing service that is given here, and to qualify this statement I would like to say we of the Canadian Nurses' Association, when we needed a very extra special nurse in our national office, came and got her in St. John's, Newfoundland. This alone means an awful lot. I suppose after that I would be very ungrateful if I asked why the ratio of nurses to population here is about three times lower than the national average. If organizations like ours come and get your nurses, this would not be fair.

DR. McGRATH: Well, as you know, the institution of marriage is our greatest enemy.

COMMISSIONER GIRARD: We can't quarrel with that.

DR. McGRATH: No. We just can't get more. Every year we have a very substantial drop balance in our estimates for nurses' salaries which we cannot expand because we cannot get the nurses. I think that is a problem not peculiar to Newfoundland, although it is probably more peculiar to us because of the isolated places that need them so badly.

COMMISSIONER GIRARD: Have you done anything in the scholarship system whereby the nurse must come back

[illegible] y place we could send the doctors out. We [illegible] to bring the patient in -- sometimes to the [illegible] in St. John's and sometimes to the nearest [illegible] to which they can be taken.

COMMISSIONER GREEN: Mr. Chairman, I have [illegible] special question to ask, but I would like to make a note of commendation to the Minister of Health of this Province for the excellent nursing service that is given here, and to qualify this statement I would like to say [illegible] of the Canadian Nurses' Association, when we needed a very extra special nurse in our national office, came and got her in St. John's. Nowfoundland. This alone means an awful lot. I suppose after that I would be very ungrateful if I asked why the ratio of nurses to population here is about three times lower than the national average. It [illegible] would not be fair.

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COMMISSIONER GIBBS: Have you some amphibious [illegible] system whereby the nurse must come back

to practise here after going away?

DR. McGRATH: We do training courses, yes -- graduate training courses.

COMMISSIONER GIRARD: But there is no tie on the nurse taking post-graduate courses outside to come back to Newfoundland?

DR.McGRATH: Yes, there is a tie. She is under obligation to work back here for a certain length of time -- usually a year. However, there is simply such a shortage of nurses we cannot possibly fill all our requirements. I think it was Thoreau who said "People live in a state of quiet desperation", and that is our situation.

COMMISSIONER VAN WART: Have you difficulty getting student nurses to train?

DR. McGRATH: No, we don't. We are building a new nurses' school and nurses' home which we hope will help, but it is simply a question of attrition. The nurses do not stay long in the profession. I am not sure, but some years ago we found that the average length of time of the nurse's service was less than the length of time of her training, and I think that situation is the same.

DR. MILLER: There is one interesting statistic, if one can use the singular of that word: that right now our problem of student nurses for the first time has come up pretty well to the rest of Canada with relation to population. That is only in the past year, and the outlook is perhaps a bit better than it was.

COMMISSIONER GIRARD: That is encouraging.

COMMISSIONER GIRARD: But there is no big [illegible]

[illegible]

[illegible]

of time -- usually a year. However, there is always such a shortage of nurses we cannot possibly fill all our requirements. I think it was Thoreau who said "people live in a state of quiet desperation", and that is our situation.

COMMISSIONER VAN NORT: Have you difficulty getting student nurses to train?

Dr. HOWARTH: No, we don't. We are building a new nurses' assoc. and nurses' home which we hope will help, but it is simply a question of accretion. The nurses do not stay long in the profession. I am not sure, but some years ago we found that the average length of [illegible] time of her training, and I think that situation is the same.

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COMMISSIONER BALTZAN: Dr. Miller, one more point on the original question: would something of this nature help the placement of medical assistants in the distant areas; it is a problem not here but, as you know, pretty general. For instance, in your far-flung areas would local hospitals fill the bill for attracting physicians and in rendering service locally, and are the roads sufficiently good enough 10, 15 and 50 miles so that patients could be taken into a small hospital if it is several hundred miles away?

DR. MILLER: I think if we had not built 15 or 20 small hospitals that there would be no medical service in these areas today.

COMMISSIONER BALTZAN: And in the still unreplenished areas would an extension of the same thing modify the condition?

DR. MILLER: I don't follow.

COMMISSIONER BALTZAN: If you had more of these further away in other places that hadn't access to doctors or to medical assistants -- of your hospitals that you mention, if more were placed in the other areas?

DR. McGRATH: I think I would like to comment on that. It is a very difficult thing to decide because if we were to open up -- I would not say we would not wish to open up some more, but there would have to be a limit, because these hospitals cannot provide first-class hospitalization. That means that you are developing a second-grade type of service, and also you are spreading your medical personnel too thin; you are putting them in places where they cannot serve a great number of people. So, we

[illegible] R BARTZAN: Dr. Miller, one more [illegible] latent areas; it is a problem but here can, a year from [illegible] would local hospitals fill the bill for obstetrics gynecologic and in rendering service locally, and are the roads sufficiently good enough 10, 15 and 50 miles so that patients could be taken into a small hospital if it is several hundred miles away?

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COMMISSIONER BARTZAN: And in the still unexplorated areas would an extension of the same thing [illegible]

COMMISSIONER BARTZAN: If you had more of these further away in other places that made it access to doctors or to medical statistics -- of your hospitals that you mentioned, if more were placed in the other areas?

DR. MCCOLLUM: I think I would like to comment on that. It is a very difficult thing to decide because if we were to open up -- I would not say we would not wish to open up some more, but there would have to be a limit, limitation. That means that you are developing a second grade type of service, and also you are spreading your medical personnel too thin, you are pulling them in places where they cannot serve a great number of people. So, we

have to some extent been looking at the possibility of bringing the patient to the hospital rather than the hospital to the patient. There are areas in Labrador where no matter how good a hospital or staff you have, they cannot reach more than a few hundred people. It doesn't make economic sense to do that too much. Some of it, yes. There are places where we still do it, but it is not a program that could be just increased indiscriminately. You would have to consider whether or not it was good business to do it, and in many cases it is much better for the patient and organization to send out a 'plane or heli copter and bring that patient into an existing facility. That is not a very clear answer, but it does you give an idea.

COMMISSIONER BALTZAN: I think that not only answers it here, but in many other distant areas. Thank you very much.

COMMISSIONER FIRESTONE: Mr. Minister, if I may crave your indulgence I have a number of questions to ask, and may I suggest if some of the answers are not available the Commission would be very happy if some of the information could be made available to us subsequently in writing.

My first question relates to paragraphs 2 and 4 of your submission, and you speak in paragraph 4 of an infant mortality rate for Newfoundland as 37 per 1,000, pointing out the dramatic improvement that has taken place over a period of 20 years, of from 91 to 37 per 1,000, or by something like 150%. This is a very remarkable improvement and one that everybody in Newfoundland and the rest

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[illegible] to the patient. There are areas in Labrador where
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and 4 of your submission, and you speak in paragraph 4 of
an infant mortality rate for Newfoundland of 37 per 1,000,
pointing out the dramatic improvement that has taken place
over a period of 20 years, of from 61 to 37 per 1,000. [illegible]
[illegible]
most are one that everybody in Newfoundland and the rest

of Canada must be happy about. In paragraph 2 you say the infant mortality rate of 39 per 1,000 compares with 28 per 1,000 for Canada as a whole. The question is, what are some of the reasons for the infant mortality rate being somewhat higher in your Province than the rest of Canada, and is the reason perhaps somewhat similar to what you have told us in connection with the mortality rate due to tuberculosis?

DR. MILLER: I think the same answer would cover it, sir.

COMMISSIONER FIRESTONE: Are there no special circumstances that apply to infant mortality as distinguished from mortality rates in the case of tuberculosis?

DR. MILLER: I think there are a number of factors, but I think what Dr. McGrath said a few moments ago about tuberculosis, that it is only in recent years we have got onto this problem; we were late in starting.

COMMISSIONER FIRESTONE: What are some of the special factors you mention that are contributing to this higher rate?

DR. MILLER: I think if we had more doctors and more nurses that this figure would come down.

COMMISSIONER FIRESTONE: How about preventive medicine? How about education?

DR. MILLER: I think increased preventive measures would do it. Not too many years ago -- well within my memory -- only about 15 percent of babies were being born in hospital. I believe our figure for 1960 was 70%, and that is low compared with most Provinces.

DR. McGRATH: One very strong reason is

somewhat higher in your Province than the rest of Canada, and is the reason perhaps somewhat similar to what you have told us in connection with the mortality rate due to tuberculosis?

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COMMISSIONER FERGUSON: Are there no special circumstances that apply to infant mortality as distinguished from [illegible] factors, but I think what Dr. Murrell said a few moments ago about tuberculosis, that it is only in recent years we have got into this problem, we were late in starting.

COMMISSIONER FERGUSON: What are some of the special factors you mention that are contributing to this higher rate?

DR. MURRELL: I think if we had more doctors and more nurses, that this figure would come down.

[illegible] medicine? How about education?

DR. MURRELL: I think increased preventive

isolation, and because of isolation the lack of pre-natal care. That would not be the only reason, but a very operative one.

COMMISSIONER FIRESTONE: This is the point I was driving at: whether you have something in mind -- a program under way -- to improve pre-natal care not only in the settled areas, but probably in the outlying areas as well?

DR. McGRATH: To this extent, that there has been a vast increase in the number of babies born in hospital; which certainly means they get better care, and if we can increase our personnel in the isolated areas, if we had twice as many nurses, or three times as many, which is what we need, then I think this problem would show immediately a beneficial effect from that increased attention. Geography is our great enemy there in Newfoundland. There are areas in which it is almost impossible to contemplate a really effective medical service. It cannot be done because both economically and from the point of view of the possibility of getting staff, you can't get them. The areas I spoke of a moment ago, where the doctors would have only a few hundred people: well, we don't have that many doctors. Building of roads, of course, will improve it, and the Government of Newfoundland has carried out a very strong road program, and that has reduced the isolation in many places, and in many of these places it will be possible to provide the pre-natal care, but it is not much use telling people they should have it if you can't provide it for them. I would think isolation is the biggest single cause because with that is linked up the

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lack of service. I don't think there is anything in the climate or the environment which would be responsible; I think just lack of medical care is the essence of it. I think Dr. Miller will probably agree with me on that.

COMMISSIONER FIRESTONE: I take it, Mr. Minister, you are conquering some of the disadvantages of geography, as you have just pointed out to the Commission, and I presume that when we are talking of providing additional medical services we are talking about providing them in areas where it is economically feasible and practical?

DR. McGRATH: Practical; not so much economical. We don't look at it entirely from an economic point of view, but being realists, if the economic cost of a thing is out of all proportion, you can't do it. We don't expect an isolated area to provide a very large proportion of its own medical costs. It is realized they must be highly subsidized, and the more isolated it is the higher is the subsidization.

COMMISSIONER FIRESTONE: What you are really telling us is that if Newfoundland could get some more help to improve its transportation system, this would help you in providing better medical service?

DR. McGRATH: And the other is if we could get more personnel, even in our present financial framework. It is not entirely a financial problem. It is to some extent, but not entirely. We have drop balances every year on both medical and nursing services. Obviously, if we cannot spend the money we have, then money alone is not the answer.

COMMISSIONER WHEELWRIGHT: I take it, Mr. [illegible], you are concerned some of the disadvantages [illegible]ly, as you have just pointed out to the Commission, and I presume that when we are talking of prefilling [illegible] there in areas where it is economically feasible and practical.

DR. MOSHER: Practically not so much economical. We don't look at it entirely from an economic [illegible] a system is one of all production, you can't do it. We don't expect in isolated cases to provide a very large production of its own medical needs. If is realized they must be highly subsidized, and the more isolated it is the harder to the subsidization.

COMMISSIONER WHEELWRIGHT: What you are really [illegible] is that if a-[illegible] could get some more help to improve the transportation system, this would help you in providing better medical service.

DR. MOSHER: And who then is it we could get more personnel, from the current financial troubles. It is not entirely a financial problem. It is to some extent, but not entirely. We have done business among people who have been medical and nursing services. Obviously if we cannot spend the money we have, then money alone is

COMMISSIONER FIRESTONE: You are quite right, sir. If I may turn to paragraph 6 on page 7, you say many towns organized in recent years have had so many basic problems that they have still been unable to contribute financially to health services. What is being done in Newfoundland to strengthen municipal organization to encourage some of these new municipalities to develop local services for their local citizens, particularly in the field of health?

DR. McGRATH: Quite a lot is being done, but not in the field of health, I am afraid, except secondhand. You must remember that until comparatively recently there was no corporate organization outside the City of St. John's. The idea of small towns and small villages having a responsibility is a new thing. It has had to be sold, and the Government have a special department of municipal affairs, one of whose duties is to encourage the formation of local bodies of this kind and to assist them financially. When a small town wishes to incorporate the Government gives them a basic grant -- I can't tell you exactly what -- and along certain fields will put up dollar for dollar to match the taxes raised in the town, which money goes to the corporation and is under their control. Very few of these towns had such things as water and sewage. These are what we mean by basic problems. A town in other places probably has had its water and sewage for hundreds of years; their ancestors took care of that, and they at the present time only have to consider the maintenance of such things. All our small towns are faced with the problem of the capital cost

Dr. McGARTH: Quite a lot is being done.

[illegible]

reconstruction. You must remember that until comparatively recently there was no suitable organization outside the City of St. John's. The idea of small towns and villages moving a responsibility to a new thing. It has had to be said, and the Government made a special department of municipal affairs, one of whose duties is to encourage the formation of local bodies in towns from one to assist them financially. When a small town chooses to incorporate the Government gives them a small grant. I can't tell you exactly what -- and along certain lines will put up dollar for dollar to match the taxes raised in the town. Much money goes to the incorporation and to under their control. Very few of these towns had such things as water and sewage. These are what we mean by basic conditions. A town in other places probably has had

of doing things which elsewhere are taken for granted, and the Government feels that it would be an impossible burden to lay on the municipalities any responsibility for health matters. They just could not do it. We hope it is not going to last, but at the present time the Government does not expect municipalities to provide any health services, and I think it would be some time before it would be reasonable of us to do it.

COMMISSIONER FIRESTONE: You are saying that municipalities are largely engaged in creating the physical facilities and that health facilities will come later?

DR. McGRATH: They have these capital expenditures in some cases, but, of course, they raise a certain amount by local taxation and by issuing bonds which are usually, but not always, guaranteed by the Government. But the issue of bonds is limited to what is expected that the municipality will support. We are not waiting for the municipalities to provide the health services, we are waiting for the municipalities to provide some of the cost.

COMMISSIONER FIRESTONE: Yes, this is a very good point, Mr. Minister; the services are being provided. The question I am driving at is whether one can expect, as the municipalities are getting better organized and they are able to raise revenue locally, whether they can share some of the cost and whether they can ---

DR. McGRATH: Yes, we feel that that will come, but we don't feel that it has come. We have to consider that they have to get rid of their capital burdens before we could expect them to share in capital costs of this kind.

COMMISSIONER FIRESTONE: Getting rid of capital burdens may take a long time, and I am just wondering if there are other municipalities which pay for their capital expenditures on a continuing basis and still pay the operating costs?

expected that the municipality will suffer. We are not waiting for the municipalities to provide the health services, we are waiting for the municipalities to provide some of the cost.

COMMISSIONER FRANCHON: Yes, this is a very good point, Mr. McIntosh; the services are being provided. The question I am involved at is whether one can expect, as the municipalities are getting better organized and they are able to raise revenue locally, whether they can share some of the cost and whether they can ---

DR. MCCONTAN: Yes, we just think that will consider that they have to get rid of their capital burden before we could expect them to share in general services of this kind.

COMMISSIONER FRANCHON: Getting rid of capital burdens may take a long time, and I am just wondering if there are other municipalities which pay for

DR. McGRATH: I am in full agreement with you theoretically, but practically I don't feel they are ready for it, and I think it would be purely an imaginary transaction, because we would pick up the deficit.

COMMISSIONER FIRESTONE: In other words, you feel that the municipalities have not reached the stage where they can impose realistic levels of local taxes?

DR. McGRATH: That is correct.

COMMISSIONER FIRESTONE: Thank you for answering the question.

If I may turn to paragraph 10 on page 8. You say that there are no community clinics available for the mentally ill, they are not in existence at the present time. Are there any plans to develop such community clinics?

DR. MILLER: There are, sir.

COMMISSIONER FIRESTONE: Can you tell us a little more about that?

DR. MILLER: Again it will be as facilities and personnel become available. We don't have what has developed in other provinces in Canada where we have these clinics which are partially supported in the communities and by the communities, and I think it is a matter of personnel in this highly specialized field.

COMMISSIONER FIRESTONE: You make the statement that you plan to do something about it as facilities and personnel become available. Are you planning to build some facilities, some clinics?

DR. MILLER: Well, there are two hospitals

DR. [illegible]: I am in full agreement with you theoretically, but practically I don't feel they are [illegible] transaction, because we would [illegible] the [illegible].

[illegible] That is correct.

[illegible] answering the question.

If I may turn to paragraph 10 on page 6. You say that there are no community clinics available for the mentally ill. They are not in existence at the present time. Are there any plans to develop such community clinics?

DR. MILLER: There are, sir.

COMMISSIONER SINCLAIR: Can you tell us a little more about that?

Dr. MILLER: Again it will be an facility developed in some community in Canada where we have these clinics which are generally supported by the communities [illegible].

[illegible] mean that you must be an enabling about it as facilities and personnel become available. Are you planning to build [illegible]?

[illegible]

under construction in Newfoundland at the present time, general hospitals with psychiatric units in them.

COMMISSIONER FIRESTONE: Are you endeavouring to attract psychiatrists to come to the Province of Newfoundland and establish themselves in practice here so that you will have the personnel to treat the people?

DR. MILLER: So far we have limited our efforts to getting sufficient personnel to carry what we now have. We don't have sufficient personnel in psychiatry at the moment to carry our in-patient services.

COMMISSIONER FIRESTONE: What are you doing to attract qualified psychiatrists to come and stay and practise here? Are you doing anything to persuade them, induce them, hit them over the head?

DR. MILLER: We have not been too successful in obtaining trained psychiatrists, but we have a training program which we feel compares favourably with the rest of Canada.

COMMISSIONER FIRESTONE: And you hope to be able to obtain a sufficient number to meet your needs?

DR. MILLER: If they are not attracted to British Columbia and elsewhere, and places south of the border. This has been one of the few disadvantages of Confederation; it is too easy to move around.

DR. McGRATH: There are the financial inducements.

COMMISSIONER FIRESTONE: There are other attractions besides finances, especially if you look at the beauty of Newfoundland.

I take it, Mr. Minister, from what you said

and and sabbatical terminal fees in practice here so that you will have the personnel to teach the people?

MR. MILLER: So far we have limited our

now have. We don't have sufficient personnel to payroll at the moment to carry on in perfect service.

COMMISSIONER FIRESTONE: What are you doing to attract qualified psychiatrists to come and stay and practice here? Are you doing anything to persuade them, induce them, bit them over the head?

to outstanding trained psychiatrists, but we have a training program which we feel compares favourably with the best of Canada.

COMMISSIONER FIRESTONE: And you hope to be able to obtain a sufficient number to meet your needs?

MR. MILLER: If they are not attracted to British Columbia and elsewhere, and place north of the border. This has been one of the few disadvantages of Confederation; it is too easy to move around.

MR. MORRIS: There are the financial

There are other

in the oral presentation and in the whole essence of the brief and also supported by what the Deputy Minister said, that one of your key problems was to get medical and other qualified health personnel to have expanded health services. Has your Province made an estimate of what your health personnel requirements will be in the next five years? I am talking of doctors, nurses and dentists and other health personnel, and how you would expect to obtain that personnel, and if that estimate is not available, could it be prepared and made available to the Commission?

DR. MILLER: It is not available, but something of that nature could be provided.

DR. McGRATH: The reason it is not available is that we know we are not going to get even near what would be reasonable, apart from a number of personnel, because we know we are not going to get too many. I think we would be afraid to put it on paper.

DR. MILLER: I think we would regard it at the moment as a highly theoretical exercise.

THE CHAIRMAN: Now, gentlemen, on the assumption that there could be a comprehensive medical services plan formulated for the whole of Canada, including Newfoundland, does it follow from what you said that you wouldn't be in a position, Newfoundland wouldn't be in a position to put such a program into effect if one was recommended or one was effected by the Government?

DR. McGRATH: I don't think we would be able to get the personnel, no, even if the financial difficulties were overcome, and I think they could be. It would take some time before we could get the personnel. We

[illegible] personnel requirements will be in the next five years. I am talking of doctors, nurses, and dentists and other health personnel, and how you would expect to obtain that personnel, and if that estimate is not available, could it be prepared and made available to the Committee?

DR. MILLER: It is not available, but some thing of that nature could be provided.

M. MORRIS: The reason it is not available is that we know we are not going to get even near what would be reasonable, except from a number of personnel, because we know we are not going to get too many. I think we would be afraid to put it on paper.

DR. MILLER: I think we would regard it as [illegible]

Sandland, does it follow from what you said that you would not be in a position, Mr. Sandland, would not be in a position to put down a program into effect if one was recommended or was ordered by the Government?

MR. MORRIS: I doubt that we would be able [illegible], no, even if the financial difficul- [illegible] some before we could get the personnel. We

would be in competition with the rest of Canada to get the personnel.

COMMISSIONER FIRESTONE: Mr. Minister, I would like to come back to your point of a theoretical exercise. I presume if you are advising your Minister as to what the requirements of your Province are you would have some ideas of what the Province needs on a realistic and practical basis. This Commission, in order to make recommendations to the Federal Government, has to base its recommendations on a realistic assessment of what is desirable and what is feasible. If we don't get the information from the people in the Province, where are we going to get it?

DR. MILLER: I have already agreed to get it for you, sir.

COMMISSIONER FIRESTONE: Then we are both agreed that this is rather a practical exercise.

May I proceed? Now, let's assume we know from you and understand from you what are the requirements on a realistic and practical basis. Could we then have some suggestions from you as to how those requirements could be met? I am thinking not only of the scholarship system which you have introduced, which I think is well-advanced and has set a good example to other Provinces, but I think there are other means by which this could be achieved, and, if so, what are your proposals? We have just come back from Halifax where we have heard a submission from Dalhousie University, both the Dean of the Medical Faculty and the Dean of the Dental Faculty, and they have told us the time it would take to train men, and

the Dean of the Faculty of Medicine said it would take 10 to 15 years of training to provide really the large number of medical men which would be required to increase substantially the health services in the Atlantic region, and the Dean of Dentistry told us it may take 20 years to train the number of dentists required to bring up the ratio to population to the Canadian average. Now, these are long periodsoof time, 10 to 20 years, and the question we put to the members of the medical faculties of Dalhousie University was: is there something that could be done to speed up that process, and I would like to ask the same question from you, sir.

DR. McGRATH: Well, I have strong feelings on this point, and I have for quite a long while felt that the training courses in medicine particularly are not realistic and unnecessarily long, and that is the three-year pre-medical course. It is a time-waster, in my opinion, and, secondly, it acts as a barrier to young men who might otherwise go through medicine. I can conceive that one-year pre-medical makes sense, it gets the boy used to the laboratory room, and so on, but why you should have three years I have never been able to understand, and my own conviction is that it is either by people led away by too much enthusiasm for education or it is a barrier to keep people out at a time when the profession thought there were too many people. It would be my opinion that this could be cut to the benefit of everyone.

COMMISSIONER FIRESTONE: Mr. Minister, is there anything you wish to add in the written supplementary brief we will get from you?

DR. McGRATH: Surely.

COMMISSIONER FIRESTONE: And you will take account of the various questions asked which may be more appropriate to answer in a written submission.

DR. McGRATH: We would be very glad to do it.

COMMISSIONER FIRESTONE: If I may turn to paragraph 13 on page 9 and paragraph 15 on page 11. You say in paragraph 13 that drugs are supplied at cost through the cottage hospitals, and you say in paragraph 15 that free drugs are provided through retail pharmacists, cottage hospitals or the Central Pharmacy operated by the Department of Health in the case of indigents.

DR. McGRATH: That is correct.

COMMISSIONER FIRESTONE: Now, sir, how do you purchase drugs?

DR. McGRATH: Well, there are several ways in which we purchase them. Our own Central purchases are done by tendering. The description of the drug is sent out to the various firms through the Department of Supply. Any firm that is interested in securing Government orders would write to the Department of Supply and say they wish to have the opportunity to tender, and usually they say what particular field they want to tender in, and the drugs are then purchased, not entirely on a price basis, but, of course, the question of cost is a matter of very strong consideration. We have, I think, the same problem there that almost any place that purchases drugs has, and that is, are drugs cheap? If the drug is offered at a cheap price from what we feel is a reliable source, we accept it,

and if we felt it was not a reliable source we would not buy it on price alone. The drugs then go to the hospitals and they are sold to the public at cost plus, 5%, I think, and in the case of indigents there is no charge. In a place where there are drugstores we usually supply prescriptions which are filled at these drugstores. We try not to be a competitor to the drugstore; we feel that the drugstore is a very useful institution and we don't want to discourage that type of business. Does that cover your point?

COMMISSIONER FIRESTONE: It covers it rather adequately, sir, and I am very obliged to you for this comprehensive answer.

DR. McGRATH: There is a list sent out to the doctors of approved drugs. It is so extensive that I don't think anybody feels that they are limited; it is a very wide one, and if for any reason - sometimes we find a doctor from the old country wants to use a drug that is not available here and there may not be a compendium, we usually give it to him.

COMMISSIONER FIRESTONE: Do I understand that all the drugs that you distribute are centrally purchased?

DR. McGRATH: Yes; except those that are filled on prescription.

COMMISSIONER FIRESTONE: Would it be possible, sir, to obtain from you a list of drugs, the major types of drugs that your Department has been purchasing in the last six-month period, with the name, description, source and price stated and comparable prices charged at a

[illegible]

[illegible]

[illegible]

retail level?

DR. McGRATH: Now, the comparable prices charged at a retail level, I couldn't say with certainty that we could get that. We will endeavour to do it. Our own costs we can give to you. If we buy and sell a drug under a generic name and a retailer - one retailer may do that also and another retailer may be selling under the trade name at several times the price, and we don't know the reason. It may be difficult to do it.

COMMISSIONER FIRESTONE: If you find you have a certain drug from a certain company at a certain time under a certain name you could ask the retailer what he would sell this identical drug under an identical name at retail. It would help us to come to grips with this problem; and the complaint we hear is that drug prices are exorbitant.

DR. McGRATH: Yes, on the face of it we feel there may be some truth in the complaint that drugs are expensive. But I can quite see that there is every need, and we would be happy to do it.

COMMISSIONER FIRESTONE: The Royal Commission is in the same boat as yourself; we are just trying to establish what the facts are without pre-judging the situation in any way whatsoever.

Before proceeding any further, Commissioner Girard has a question.

DR. MILLER: You wish every drug in the last six-month period?

COMMISSIONER FIRESTONE: We would be quite happy to leave this to your good judgment, and I presume

[illegible]

[illegible] in order to see if we can give to you. If we buy and sell a drug under a generic name and retailer - one retailer may do [illegible] another retailer may be selling under the trade name at several times the price, and we don't know the reason. It may be difficult to do it.

COMMISSIONER FIRESTONE: If you find you have a certain drug from a certain company at a certain time under a certain name you could ask the retailer what he would sell this identical drug under an identical name at retail. It would help us to come to grips with this problem, and the complaint we hear is that some prices are exorbitant.

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[illegible] is in the same boat as yourself; we are just trying to establish what the facts are without rushing into situation in any way whatsoever.

[illegible] raised then a question.

DR. MILLER: You mean every drug in the [illegible]

COMMISSIONER FIRESTONE: We would be quite

that the major drugs, the more important and common drugs, are quite adequate. We are not interested in an exhaustive list. We are interested in typical drugs at various price levels.

COMMISSIONER McCUTCHEON: And, of course, quantity is very important.

DR. McGRATH: Yes.

DR. MILLER: What you want, in other words, is a recommended retail selling price?

COMMISSIONER FIRESTONE: It would be very helpful to have that one as well, and an indication whether retailers, in fact, sell at a recommended price below or above, if such information is available.

COMMISSIONER GIRARD: Mr. Minister, you mentioned a few minutes ago that after drugs were purchased, they were distributed to doctors and nurses. I would like to know how nurses handle drugs, and how they distribute drugs, in what method and through what medium?

DR. McGRATH: When I said nurses, I should of course have said district nurses who are acting through the Department of Health. The nurses issue a limited list of drugs that we feel would be the obvious ones she would need, and it would be proper for her to use. She keeps a receipt book, and when she issues a drug to the patient and the patient pays for it it is entered in the receipt book, the patient gets a receipt, and the copy remains in the receipt book. If she issues without charge, she makes a notation in the receipt book that this drug was given without charge.

COMMISSIONER GIRARD: Would she ever distribute drugs without doctors' prescriptions?

DR. McGRATH: Yes, exactly as a medical practitioner, in isolated places.

COMMISSIONER GIRARD: With the blessing, or under the supervision ---?

DR. McGRATH: Sometimes under the supervision of the local doctor, or sometimes under the somewhat attenuated supervision of the Department of Health.

COMMISSIONER GIRARD: She is not directly issuing drugs, but issuing them for the doctor?

DR. McGRATH: No, she is issuing them on her own judgment. For example, a district like St. Marys, where there is a doctor in one end of the district and the

need, and it would be proper for her to use. She keeps a receipt book, and when she issues a drug to the patient and the patient pays for it it is entered in the receipt book, the patient gets a receipt, and the copy remains in the receipt book. Would that give a guarantee in the receipt book that this drug was given without charge.

COMMISSIONER GIRARD: Would she ever give

DR. MOSHER: Yes, exactly as a medical prescription, in isolated cases.

COMMISSIONER GIRARD: When the dispensary, or

DR. MOSHER: Sometimes under the supervision of the supervision of the Department of Health.

COMMISSIONER GIRARD: She is not directly issuing drugs, but issues them for the doctor?

DR. MOSHER: No, she is issuing them on her own authority. For example, a diabetic like Dr. Smyre, is a dresser in one end of the

nurse in the other end of the district, the doctor in that case would have only quite a limited supply and type of drugs, and such things as antibiotics and the more dangerous drugs, she would act only on the orders of the doctor. He would say: "Give her so-and-so and I will see her tomorrow". In other places, like not far from St. John's, where the doctor is 50 miles away, that nurse would have a greater range of drugs, a greater authority to use them.

COMMISSIONER GIRARD: But would she have standing orders from the doctors to issue these drugs?

DR. McGRATH: No, not from the doctors, but she would have standing orders from us as to what she can do.

COMMISSIONER GIRARD: But from some authority?

DR. McGRATH: But a lot has to be, and is, left to her own judgment.

COMMISSIONER FIRESTONE: If I may proceed. The next question relates to paragraph 13 on page 10. You speak of a medical and hospital service program which you have provided for children under 16. What has been the experience under this program, and I am particularly referring to the provision of preventive medicine, what this may have done to improve the health of the young people?

DR. McGRATH: Well, I think Dr. Miller could perhaps tackle that one.

DR. MILLER: I don't think at the moment, sir, that there is anything in the nature of figures available that would indicate this, but there is no doubt

her tomorrow. In other places, like our Ser-

would have a greater range of drugs, a greater authority to use them.

COMMISSIONER GIRARD: But would she have essentially orders from the doctors to issue these drugs?

Dr. McGRATH: No, not from the doctors, but she would have standing orders from us as to what she can do.

COMMISSIONER GIRARD: Not from some authority?

Dr. McGRATH: Not a list has to be, and is, left to her own judgment.

COMMISSIONER FIRESTONE: If I may proceed. The next question relates to paragraph 13 on page 10. You speak of a medical and hospital service program which you have provided for soldiers under 16. What has been the experience under this program, and I am particularly referring to the prescription of preventive restrictions, what

at all in my mind that children are getting into hospitals for treatment who did not get in before because of certain deterrents.

COMMISSIONER FIRESTONE: Can we pursue a little bit further the preventive medical aspect? Do those children get a regular medical examination?

DR. McGRATH: In some places, yes. In some places, no.

COMMISSIONER FIRESTONE: Do they get such things as orange juice, milk, or other things?

DR. McGRATH: It is made available, but the distribution is spotty, because again of lack of personnel and organization in some of the outlying places. Orange juice is provided, but I don't think the orange juice program has been a startling success.

COMMISSIONER FIRESTONE: Are you providing for dental treatment for the children?

DR. McGRATH: We have a limited program, but it does not go very far, because we can only do it where there is a dentist who has time. In St. John's most of them do it. A number of them outside St. John's do it part-time, they work for the children in the morning and on their own private practice in the afternoon, but we don't offer such a service to the public at large. We say, here is a district where it can be done, but it is very limited, and I think we limit it to 5 to 7 years old, because we have dental advice that that is the least that can be done.

COMMISSIONER FIRESTONE: But you are making progress in this direction, you have to limit your service

COMMISSIONER FLANSTONE: Can we pursue a little further the preventive medical aspect? Do those children get a regular medical examination?

DR. MCGRATH: In some places, yes. In some places.

COMMISSIONER FLANSTONE: Do they get such

DR. MCGRATH: It is more available, but a distribution is uneven, because quite of lack of personnel and organization in some of the outlying places. Transportation is provided, but I doubt that the average person has been a shattering success.

COMMISSIONER FLANSTONE: Are you providing for dental treatment for the children?

DR. MCGRATH: We have a limited program, but it does not go very far, because we can only do it where there is a dentist who has time. In St. John's such can then do it. A number of them outside St. John's do it part-time, then work for the children in the morning and on their own private practice in the afternoon. But we don't offer such a service to the public at large. We may have in a district where it can be done, but it is very limited, and I think we limit it to 5 to 7 years old, because we have dental service that is the least that

in view of lack of personnel?

DR. McGRATH: We think the service we give is an intelligent approach to the problem, but the problem is so huge and the places where we can exercise work of that kind is rather disheartening, but we feel it is well worth doing, if only partially done, it is good from the point of view of public education.

COMMISSIONER FIRESTONE: Perhaps I can see a hopeful note in this respect, Mr. Minister, that you are endeavouring to increase the personnel and the facilities in your Province, and as you succeed, I presume you will be doing more in the field of medical service to the young?

DR. McGRATH: Definitely.

COMMISSIONER FIRESTONE: And if I understand your Deputy Minister correctly, this is a promising program, and while you have no figures, you can see some improvement, and you can expect more improvement as your services can expand?

DR. McGRATH: Yes, the apparent elimination of diphtheria for instance. We have had pretty good coverage on that over the years, and the progress has been quite satisfactory. We had one diphtheria death two or three years ago, and I think that shows these things can be dealt with when you have the personnel to do it.

COMMISSIONER FIRESTONE: In the supplementary brief you will be submitting, would it be possible for you to outline some of the additional things that can be done in providing increased medical services for the young, what it would involve, what it would cost on a realistic

point of view of public education.

COMMISSIONER FIRESTONE: Perhaps I can see a hopeful note in this respect, Mr. Minister, that you are endeavoring to increase the personnel and the facilities in your services, and as you succeed, I presume you will be doing more in the field of medical services to the young?

MR. McDIVITT: Definitely.

COMMISSIONER FIRESTONE: And if I understand your Deputy Minister correctly, this is a promising program and while you have no figures, you can see some improvement and you can expect more improvement as your services can expand.

MR. McDIVITT: Yes, the apparent elimination of diphtheria for instance. We have had pretty good coverage on that over the years, and the program has been quite satisfactory. We had one diphtheria death two or three years ago, and I think that shows that when we do deal with it when you have the personnel to do it.

Under you will be submitting, would it be possible for you to outline some of the additional things that can be done

[illegible], what it would cost on a realistic

basis, Mr. Minister, and where the money would come from?

Now, may I turn to paragraph 16 on page 11.

DR. McGRATH: Perhaps, sir, I should have mentioned there when we were talking about what is actually being done, the B.C.G. program which has been carried out very intensively, and I think again I am safe in saying we have had practically no T.B. or meningitis incidence for a number of years. That procedure is comparatively simple. Dental work, which is not simple, breaks down on a volume basis.

COMMISSIONER FIRESTONE: That is most encouraging. Paragraph 16, page 11. You say that as far as your relations with the Department of National Health is concerned, that one difficulty you are facing is an excessive amount of paper work. This is a polite way of saying there is too much red tape. Can you suggest, or can you make proposals to this Commission on how this red tape can be cut, or reduced, and if you do not wish to make the proposals now, could you make the proposals in your supplementary submission?

DR. McGRATH: Yes, I think we would prefer to do it that way.

COMMISSIONER FIRESTONE: I turn now to paragraph 19, page 13. You say in this paragraph that the amount of the contribution from the Government of Canada under the Hospital Construction Grant is limited to $2,000 per bed, and you say that at present building costs this rarely amounts to more than 20% of the total cost, and in most cases, to 15% or less. Would you recommend an increase in this percentage, and if so, what

tradeoffs for a number of years. That procedure is commendable.

down on a volume basis.

COMMISSIONER FERGUSON: That is more encouraging. Paragraph 16, page 11. You say that as far as your relations with the Department of National Health is concerned, that one difficulty you are facing is an excessive amount of paper work. This is a polite way of saying there is too much red tape. Can you suggest, or can you make proposals to this Commission on how this red tape can be cut, or reduced, and if you do not wish to make the proposals now, could you make the proposals in your supplementary submission?

DR. MCDAGGIE: Yes, I think we would prefer to do it that way.

COMMISSIONER FERGUSON: I turn now to paragraph 19, page 13. You say in this paragraph that the amount of the contribution from the Government of Canada under the hospital construction grant is limited to $2,000 per bed, and you say that at present building costs this rarely amounts to more than 20% of the total

percentage would you recommend as being desirable, realistic, and practical? Would you prefer to give this answer in your written submission?

DR. MILLER: I think it is fair to say that when this thing was first thought of back about almost 20 years ago, I think it was supposed to be approximately one-third of the cost of a hospital bed. It was supposed to be equally divided between the Federal Government, the Provincial Government and local contribution. It was $1,000, and has gone up to $2,000, but it still lags far behind the original concept of one-third.

COMMISSIONER FIRESTONE: This is a helpful answer. Can we expect that you will elaborate on this in your supplementary submission?

DR. McGRATH: Yes. Again, in Newfoundland, we are in rather a peculiar position here, because of th fact that there is no municipal contribution, and our estimates of what we feel would be fair assistance from the Federal Government might be different from other Provinces. For that reason, if the original conception was a division of cost three ways, Federal, Provincial and municipal, we feel that under our circumstances we would have to ask the Federal Government to contribute one-half. Whether this is a practical suggestion as far as the Federal Government is concerned, I don't know, but we do feel that it was the intention of the Federal Hospital Grant to encourage the provision of the hospital beds. As it stands today, that is not operative in Newfoundland at all. Not one single bed in Newfoundland has been initiated because of the help of the Federal Government.

one third of the cost of a hospital bed. It was supposed to be equally divided between the Federal Government, the Provincial Government and local contribution. It was $1,000, and has gone up to $2,000, but it still lags far behind the original contract of one-third.

COMMISSIONER EDWARDSON: This is a lengthy answer. Can we expect that you will elaborate on this in your supplementary submission?

Mr. MORRIS: Yes. Again, in Newfoundland, we are in rather a peculiar position here, because of the fact that there is no municipal contribution, and our estimates of what we feel would be fair assistance from the Federal Government might be different from some Provinces. For that reason, if the original concept was a division of costs three ways, Federal, Provincial and municipal, we feel that under our circumstances we would have to ask the Federal Government to contribute part. Therefore this is a practical suggestion as far as the Federal Government is concerned, I don't know, but

It is fair to say that. I say that not as a criticism, because we get exactly what other Provinces get, but here it does not operate at all in the encouragement of provision of hospital beds, and I think the amount should be sufficiently high to effect the provision of hospital beds.

COMMISSIONER FIRESTONE: You are pointing out to us that the circumstances in the Province of Newfoundland differ to those in other provinces, and special consideration should be given to this situation, and therefore we would welcome you to elaborate on this point in your supplementary submission. If I might turn now to some of the recommendations and conclusions at the beginning of your brief. My first question relates to 6A, on page 2. You say in this paragraph that you recommend that consideration be given to a plan of special financial assistance from the Government of Canada to the Province, which would take into account existing deficiencies and needs in health and hospital services. Could we have from your Government, sir, some specific proposals as to the type of financial assistance which would be required, and the formula which should be used, and could that be included in your supplementary submission?

DR. McGRATH: I think one of the reasons we didn't go further with this, is that we hesitated to make recommendations in a vacuum, so to speak. We wished to know how this is developing in other provinces, as well as here, so we could receive some impression of what the general thinking was, as well as our own, but we will be prepared to do as you ask and try to make specific

[illegible] to say that. I say that not as a criticism [illegible]

[illegible]

[illegible]

[illegible]

[illegible] and differ to those in other provinces, and special consideration should be given to this situation, and therefore we would welcome you to elaborate on this point in your supplementary submission. If I might turn now to one of the recommendations and conclusions at the beginning of your brief. My first question relates to 6A, on page 6. You say in this paragraph that you recommend that consideration be given to a plan of special financial assistance from the Government of Canada to the Provinces, which would take into account existing deficiencies and needs in health and hospital services. Could we have from your Government, sir, some specific proposals as to the type of financial assistance which would be required, and the formula which should be used, and could that be included in your supplementary submission?

Dr. MORAN: I think one of the reasons we [illegible] recommendations in a manner, so to speak. We wished to know how this is developing in other provinces, as well as here, so we could receive some impression of what the general tendency was, as well as our own, but we will be [illegible] to do as you ask and try to make specific

suggestions.

COMMISSIONER FIRESTONE: Mr. Minister, we are not putting a time limit on your submission, and you are more than welcome to consider what other Provinces are proposing and let us have your recommendations when you are prepared to do so, as long as it is done at a reasonable time before the Commission winds up its own work.

DR. McGRATH: Surely.

COMMISSIONER FIRESTONE: May I now turn to paragraph 6C on page 3. This is your recommendation concerning the speeding up of the training process of health personnel. I mentioned this matter before, and I just repeat that we would welcome specific recommendations.

DR. McGRATH: Yes.

COMMISSIONER FIRESTONE: And in those specific recommendations could you include an indication whether it would be possible to increase your health personnel to some extent, and perhaps on a temporary basis, through immigration say from the old country. Could you elaborate that point as well?

DR. McGRATH: Yes, actually we have been making every endeavour to do that, both by contacts in Great Britain and by actual visits there, recruiting visits and so on, both for nursing and medical personnel, and if we had not received recruitment from Great Britain over the past years, many of our services here would have been far worse than they are. We used to get a fair percentage of nurses from the old country, but that has dried up. I don't think there is anything we can do to

COMMISSIONER ARMSTRONG: Mr. Minister, we are not putting a time limit on your submission, and you are more than welcome to consider what other Ministers are proposing and let us have your recommendations. You are prepared to do so, as long as it is done at a reasonable time before the Commission winds up its work.

DR. McGRATH: Surely.

COMMISSIONER FINNEMORE: May I now turn to paragraph 60 on page 3. This is your recommendation concerning the speeding up of the training programs of health personnel. I mentioned this matter only a, and I just repeat that we would welcome specific recommendations.

COMMISSIONER FINNEMORE: And in those specific recommendations could you include an indication whether it would be possible to increase your medical personnel to some extent, and perhaps on a temporary basis, through immigration say from the old country. Could you elaborate that point as well?

DR. McGRATH: Yes, actually we have been making every endeavour to do that, both by contacts in Great Britain and by actual visits there, recruitment visits and so on, both for nursing and medical personnel, and if we had not received recruitment from Great Britain over the past years, many of our services here would have been far worse than they are. We need to get a fair number of nurses from the old country, but most has

increase that flow from Great Britain at the present time. We have tried everything.

COMMISSIONER FIRESTONE: Have you tried to elicit some help from the Federal Government through its own immigration services?

DR. McGRATH: Yes, we have been in close touch with them and with their various sub-divisions in various towns in the old country, and I honestly believe we are doing as much as can be done, but I don't think there is much of a source of personnel to be obtained there at the present time. I have been over there several times, and Dr. Miller, and my assistant deputy is going over in a week's time. We have been doing this for several years, and have a good picture of what the situation is in the old country. They themselves, instead of being an exporter of medical men, are now an importer. As Dr. Miller has said, if you have a road accident in the United Kingdom, there are five chances to one that your doctor will be an Asiatic. The thing that has happened is that a number of men trained medically with the idea of going into the British public service.

COMMISSIONER FIRESTONE: If you have any thoughts on the matter of what could be done, perhaps from other countries, we would welcome such suggestions in your supplementary submission.

DR. McGRATH: Yes.

COMMISSIONER FIRESTONE: Paragraph 6D on page 3. When you recommend that consideration be given to increasing hospital construction grants to a more realistic level, and would you indicate in your

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COMMISSIONER FINNISTON: If you have any thoughts on the matter of what could be done, perhaps from other countries, we would welcome such suggestions

DR. McKAUGHT: Yes.

COMMISSIONER FINNISTON: Paragraph 60 on page 3. When you recommend that consideration be given to increasing hospital consultation grants to a more adequate level, and you indicate in your

supplementary submission, as I suggested earlier, as to what your views are of a more realistic level?

DR. McGRATH: Yes.

COMMISSIONER FIRESTONE: Paragraph 6E at the bottom of page 3, is that any proposed expansion in the provision of personal help services be included within the scope of the Department of Health, thus avoiding unnecessary duplication. Sir, can we assume for the moment that we had in Canada a health service program which is paid in part by contributions made by those who can afford it to this scheme, and by Governments covering the cost of the indigent, the people that cannot pay for it. Presumably, if you had such a scheme in operation, you would want to see that the scheme was solvent, that the income was equal to expenditures, and presumably you would keep separate accounts. Would you not feel that in a case like this, such a scheme would be better administrated by a separate Commission, who would ensure that the thing is run along business-like lines, with separate accounts kept, rather than by a Department of Health, where everything is thrown in the same pot? This is a difficult question to answer, because it concerns itself with matters of principle, and matters of administrative efficiency. Could that question be considered, and could we have at some stage your considered views on those points?

DR. McGRATH: The objection I make to that is that it is a highly hypothetical question, which is always difficult and undesirable to answer. Our recommendations refer to conditions in Newfoundland, and not

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DR. McGRATH: The objection I make to that is that it is a highly hypothetical question, which is always difficult and undesirable to answer. Our recommendations refer to conditions in Newfoundland, and not

the rest of Canada. This recommendation is strictly a local condition, and we feel that under local conditions it would be difficult to separate it into two parts.

COMMISSIONER FIRESTONE: Are you saying that you cannot visualize, under the conditions you face in Newfoundland, a scheme whereby people that can afford would contribute to a comprehensive health plan in the Province?

DR. McGRATH: No, I don't say that it couldn't be done, but I would think it would be difficult here, because outside the towns the number of people who would be able to pay fully for their services would be comparatively small, again because of the difficulties of transportation and so on.

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COMMISSIONER FITZSIMONS: Are you saying that

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couldn't be done, but I would think it would be difficult here, because outside the towns the number of people who would be able to pay fully for their services would be comparatively small, again because of the difficulties of transportation and so on.

Actually, that is what we have now. We have a Government scheme which for a payment of $10 a year, something close to around half the population of the country do receive their services, and they are highly subsidized. We also have the other half of the population paying when they can afford to pay. So, that is what we have at the present time.

COMMISSIONER FIRESTONE: On an individual basis?

DR. McGRATH: Yes, and on an area basis also. There are areas of Newfoundland where the cottage hospital scheme -- and we still call it that -- is operative. Sometimes the logic of why you do this in "A" and something else in "B" is not too clear; sometimes not too clear to those in "B", and sometimes not to ourselves. However, in a town where people are earning wages, such as Cornerbrook, Grand Falls and St. John's, we feel that is a place where the majority of people can pay for their services. Of course, we take care of the indigents in these places, but in the other places we know it would be impossible to have a private medical service operating. The doctors, who are reluctant enough to go there now, were even more reluctant often, because one of the things we find is that a doctor, especially from outside Newfoundland, wants some certainty about it, and if we say that there is a private practice worth $12,000 a year, that doesn't mean very much; but if we say that there is a Government practice and that we will pay him $12,500 and see to it that he gets all his supplies, that is something concrete which the man can reject or accept, and which is

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frequently accepted, but they are not inclined to go to a nebulous idea of a private practice. There are some places where there are private practices, but they are limited.

COMMISSIONER FIRESTONE: You are saying, then, you have had reasonably good experience with offering doctors salaried positions?

DR.McGRATH: Yes.

COMMISSIONER FIRESTONE: Plus the opportunity to make some extra if that opportunity arises?

DR. McGRATH: Yes.

COMMISSIONER FIRESTONE: So, it is something that has worked in Newfoundland in the outlying areas?

DR. McGRATH: Yes. There are other people present in the hall today who might not agree it has worked.

COMMISSIONER FIRESTONE: Well, we will have an opportunity of questioning them, but thank you for giving us the answer to this question.

I come now to my last question, Mr. Minister. There are in your brief a number of proposals and we have dealt with several of them, but not all of them, but could we have in your supplementary submission the overall picture as to what these various proposals would cost to develop a reasonably realistic and practical health program for the Province of Newfoundland for the next 5 years: what this would cost in terms of capital expenditures, in terms of operating expenditures, and where the money would come from -- some of it, say, from private sectors and some of it from public sectors, with the

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public sector divided into Provincial Government and Federal Government, so the Commission would have an overall view of what you are planning to do and what would be desirable and realistic, what it would cost, and where the money would come from?

DR. McGRATH: We will try and do that, but I am sure you will appreciate what you are asking, because what we would recommend as a practical procedure would depend on the sources of money. For instance, if we can start off by saying we figure the Province can afford 'X' dollars per year, then what we would recommend would have to be integrated on how many dollars are coming from some other source.

COMMISSIONER FIRESTONE: Exactly.

DR. McGRATH: So, it is a sort of a movable thing; it is like picking up mercury with a fork. However, I understand what you mean and we will come as close to it as we can. I think we will have to work on the basis of what is the utmost the Province can afford, and then the program will depend on what other sources of income there will be. If the situation were entirely done by the Province, then it is going to be limited in itself. As we don't know what the other possible sources are likely to provide, you can see how difficult it would be for us to indicate an actual working formula. It is no trouble to give you an idea that will be completely unrealistic, and it is easy enough to give a guarded one, but just to give you a formula in the absence of any real knowledge as to what funds we are going to work with -- obviously, the amount of money that is going to be available is what is

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going to affect the type of recommendation we would have to make.

COMMISSIONER McCUTCHEON: I gather you do feel you have a pretty good idea of obtaining trained personnel?

DR. McGRATH: That would be a factor.

COMMISSIONER McCUTCHEON: That, surely, would be a very important factor in setting out what might be regarded as a realistic formula?

DR. McGRATH: Yes. I think such a thing would have a number of "ifs" in it. Anything we provide you with in that way, we would be glad to elaborate on after you have received it.

COMMISSIONER FIRESTONE: That could be very helpful. I can only emphasize one point again, and that is unless we have an understanding of your own views as to what your requirements are, how you feel it should be organized, administered and financed, it is difficult for this Commission to come to grips with it, and we also would like to have your ideas of what you, yourself, feel you can do, and how much help you need on, again, a realistic and practical basis. Thank you very much for your patience with these questions.

DR. McGRATH: Thank you.

COMMISSIONER VAN WART: Mr. Minister, I would like to ask you what provision you have at present for chronic hospital care patients?

DR. McGRATH: Practically none, or very little. We have a Government institution called the infirmary, which is hopelessly out of date. It was

dangerous; we don't think it is dangerous now because we have put in automatic sprinklers, but it is certainly out of date and really beyond proper use.

There is the St. Patrick's Nursing Home which is run by the Roman Catholic Church. They have a splendid modern building, and it is an extremely good institution, but again they cannot take care of the flood of applications that come into it.

There are some other institutions for old people who are not ill, but our provision for the chronically ill is very, very limited indeed and, of course, the reason for that is that our provision for the people who are acutely ill is not as great as we would wish to have it, and there is a tendency to use what space there is for emergency work. It is not something that has been neglected. We have been working on it for some time, and we hope to relieve the situation, but it will take us some time and effort to achieve what we would wish.

COMMISSIONER McCUTCHEON: Undoubtedly, just as you have nurses who are in isolated districts who have very wide discretion in the administering of certain of the more common types of drugs, so, I have no doubt, in some of these outlying districts there will be many nurses who will attend a confinement without a graduate physician?

DR. McGRATH: That is so.

COMMISSIONER McCUTCHEON: Is the practice of midwifery authorized in this Province?

DR. McGRATH: It is, but it is gradually dying out, both because of the fact more and more patients

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A. McGRATH: That is so.

COMMISSIONER McCUTCHEON: Is the practice of midwifery encouraged in this Province?

are going to the hospitals, and from the fact that suitable people are not coming forward for training. We do have a Midwifery Act and we still train them.

DR. MILLER: This is not midwifery in the sense you may understand it. This is not a trained nurse midwife.

COMMISSIONER McCUTCHEON: That is what I meant.

DR. McGRATH: Oh, no; it is midwives in the old English sense.

DR. MILLER: Most of our district nurses have special training in midwifery.

COMMISSIONER BALTZAN: Mr. Chairman, Mr. Minister and Deputy Minister, there is a good deal of stress being laid on the fact that there is definitely quite generally a shortage of personnel at all levels, and that is a very important factor, and I think we are all conscious of this thing, and we have heard here claims for that, as we do in other places. In addition, considering as we must this is a very widely scattered country and many isolated places, and not always sufficient roads, whereas there is that deficiency in adequacy of personnel at all levels, there is also the question of these personnel, if they were available, not being accessible to the patient at some distant area, and vice versa. There is some difficulty in reverse, where the isolated person cannot get to even a near locality where there is available that service. In other words, in considering the whole factor at large throughout the country, because of our immense area, the stress is not always or entirely

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on the element of shortage of personnel as the difficulty in accessibility -- patient to doctor or doctor to patient or nurse to patient etc. -- as the element of transportation accessibility; that is another element which makes for the difficulties which we have to contend with?

DR. McGRATH: Yes. In other words, the personnel you do have spend a lot of time travelling instead of getting actual items of work done -- not through their own fault.

I might mention, because I think it would be of interest to the Commission, that the Government of Newfoundland has through its Department of Welfare, what we call a centralization scheme, and we are trying to lessen the number of these isolated places, and to any settlement that wants to move into a larger settlement, they will give substantial financial assistance to do so, and there has been quite a movement, and I think quite a number of isolated settlements no longer exist. That will have a direct bearing on medical services, and that is why I should mention that the Deputy Minister of Welfare is here, and perhaps Mr. Andrews could tell us how many settlements have moved up to the present time.

MR. R.L. ANDREWS (Deputy Minister of Welfare): Well over 60.

DR. McGRATH: 60 settlements of these isolated ones no longer exist, and that is a very encouraging demonstration, and we hope in the course of time that will help us in the health services.

THE CHAIRMAN: Is this a developing trend?

DR. McGRATH: Yes, quite definitely.

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THE CHAIRMAN: Is this a developing trend?

DR. McGRATH: Yes, quite definitely.

COMMISSIONER BALTZAN: May that be extended to say you are encouraging urbanization?

DR. McGRATH: It depends on the translation of the word "urbs", I think; but they are certainly larger, and the least number of these isolated communities the better service we can give.

THE CHAIRMAN: Dr. McGrath, coming back to this matter, on the assumption that there might be a comprehensive medical services plan, have you a view to express as to whether it should be based either wholly or in part on an insurance feature?

DR. McGRATH: I would say in Newfoundland the insurance feature would not be realistic. The difficulty of collection and so on -- I would think that in Newfoundland the probable trend would be is what we are doing now. For instance, under our hospital scheme there are no premiums available. We would have to pay it out of the ordinary revenue, perhaps finding some special means to increase the ordinary revenue to meet the extra burden, but at the present time I do not think we would tend towards considering insurance -- that is, a premium insurance scheme.

THE CHAIRMAN: I take it that is because of the particular situation in the Province?

DR. McGRATH: Yes; we are not against the idea, no.

THE CHAIRMAN: Not against it in principle?

DR. McGRATH: No. It is conceivable a plan could be developed that could have an insurance element in it. We don't have a closed mind on it; we have an open

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DR. MCGHAHEY: No. It is conceivable a plan could be developed that could have an insurance element in it. We don't have a closed mind on it; we have an open

mind on this, but I am expressing the view that in my own opinion in Newfoundland it is more likely revenue would have to come out of general revenue, but that is not because we have a preference for that method of doing it.

THE CHAIRMAN: We have heard the expression this morning "indigents": how are they ascertained?

DR. McGRATH: The welfare officer in an area is asked to pass on the person's situation. In many cases we don't ask specifically for the welfare officer's recommendation. The individual situation is probably known both to the doctor and to the nurse, but in the first instance, or if there is any doubt, especially in the matter of transportation of a patient to hospital where there is an actual payment of new monies to be made, the welfare officer will certify this patient is not in a position to pay for such service.

THE CHAIRMAN: Have you an income limitation?

DR. McGRATH: Yes, there is an income limitation. I can't give you exactly what it is, but it is easily ascertainable; and the income limitation is with reference to the size of the family and their situation and so on. The Deputy Minister of Welfare could answer that question in more detail, but that is the way it is handled. We depend on the welfare officer and his judgment. Of course, he in turn is governed by certain central instructions from head office as to policy and so on, but very largely this depends on the local welfare officer for certain types of service, and the test is not meant to be a harsh one. A person doesn't have to be without money at all. There are certain types of service, such as

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preventive services of all kinds, which are free to anybody. However, essentially, where the thought is present that this person is unable to pay, we seek our information from the welfare officer.

THE CHAIRMAN: In the event of a comprehensive medical service program, could you visualize how those who can afford to pay would have either the obligation -- well, say the obligation to make a proper payment?

DR. McGRATH: Oh yes, I think that could be done. There is nothing inherently impossible about such an arrangement, but I think in the last analysis it means a person claiming to be unable to pay would have to pass the scrutiny of a welfare officer. I don't know of any other way in which it can be done.

COMMISSIONER FIRESTONE: I am wondering, following up what the Chairman just asked you, whether in fact your present system is not already a contributory system? People are, if I understand you correctly, paying $10?

DR. McGRATH: That is right; it is a contributory system.

COMMISSIONER FIRESTONE: So, you already have a contributory system?

DR. McGRATH: Yes, but the premium is so low compared to a service -- it is not a realistic premium and not intended to be.

COMMISSIONER FIRESTONE: But I think what the Chairman and the Commission are interested in is whether a contributory system could be worked in the Province whatever the contribution may be? It may be

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lower or greater depending on what other source of revenue there will be?

DR. McGRATH: I didn't say a contributory system would be impossible, but I think a contributory system that would be realistic from the financial point of view would probably be very difficult.

COMMISSIONER FIRESTONE: But would you say the principle of a contributory system is realistic and, in fact, works already?

DR. McGRATH: Oh, yes. I didn't wish to intimate that we have any objection to the consideration of a contributory system, no.

COMMISSIONER FIRESTONE: Fine. That answers the question.

THE CHAIRMAN: Thank you very much Dr. McGrath and Dr. Miller. This has been a very helpful and outstandingly helpful contribution to the work of the Commission, and we are very grateful to you for it, and for the very pleasant manner in which you have answered all the questions put to you, and for your offer of further assistance in this supplementary brief.

DR. McGRATH: Thank you very much, Mr. Chairman.

--- EXHIBIT NO. 21: Submission of the Department of Health of Newfoundland

--- EXHIBIT NO. 21A: Annual Report of the Department of Health of the Province of Newfoundland dated 1959

--- EXHIBIT NO. 21B: Estimates of Expenditures and Revenue 1st April 1961 to 31st March 1962

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- EXHIBIT NO. 21B: Estimates of Expenditures and Revenue for April 1961 to 31st March 1962

/dpw

THE CHAIRMAN: The receipt today of this submission on behalf of the Newfoundland Federation of Labour requires that we make a change in our agenda. I think it is only fair to anyone who submits a brief or makes a submission in writing that the members of the Commission should have an opportunity to read it, to study it before it comes up for discussion. So we are going to adjourn consideration of the Newfoundland Federation of Labour brief until tomorrow morning. So there will be a change in the agenda. The next submission will be from the Victorian Order of Nurses, to be followed by the Newfoundland Medical Association, and then perhaps this afternoon, if we reach it, the Newfoundland Dental Association. Then we take up the Federation of Labour brief tomorrow morning and continue with the Newfoundland Society for the Care of Crippled Children and Adults, the Association of Registered Nurses of Newfoundland, and the Newfoundland Tuberculosis Association.

We will now hear from the Victorian Order of Nurses.

SUBMISSION OF THE VICTORIAN ORDER OF NURSES FOR CANADA ON BEHALF OF ITS BRANCHES IN NEWFOUNDLAND

Appearances: Mrs. Brian Botham
Miss L. Wall
Miss Ruby Harnett
Peter Goodridge

MISS WALL: Mr. Chairman and Commissioners, as you know, my name is Miss Wall, the Regional Director for Newfoundland. I am going to introduce Mrs. Botham, President of the St. John's Branch of the Victorian Order of Nurses. Mrs. Botham will present the submission on

think it is only fair to anyone who submits a brief or makes a submission in writing that the members of the Commission should have an opportunity to read it, to study it before it comes up for discussion. So we are going to adjourn consideration of the Newfoundland Federation of Labour brief until tomorrow morning. So there will be a change in the agenda. The next submission will be from the Victorian Order of Nurses, to be followed by the afternoon, if we reach it, the Newfoundland Dental Association. Then we take up the Federation of Labour brief tomorrow morning and continue with the Newfoundland Society for the Care of Crippled Children and Adults, the Association of Registered Nurses of Newfoundland, and the Newfoundland Tuberculosis Association.

We will now hear from the Victorian Order of Nurses.

SUBMISSION OF THE VICTORIAN ORDER OF NURSES FOR CANADA

ON BEHALF OF ITS BRANCHES IN NEWFOUNDLAND

Appearances: Mrs. Brian Botham
Miss L. Wall
Miss Ruby Hennett
Peter Goodridge

MISS WALL: Mr. Chairman and Commissioners, as you know, my name is Miss Wall, the Regional Director

I am going to introduce Mrs. Botham,

behalf of the Cornerbrook and St. John's branches.

MRS. BOTHAM: Mr. Chairman and members of the Royal Commission, ladies and gentlemen, I should first like to introduce Mr. Peter Goodridge and Miss Ruby Harnett, who are members of the Board of Management of the Victorian Order of Nurses for Newfoundland.

SUBMISSION

to the

ROYAL COMMISSION ON HEALTH SERVICES

by the

THE VICTORIAN ORDER OF NURSES FOR CANADA

ON BEHALF OF ITS BRANCHES IN NEWFOUNDLAND

5 Blackburn Avenue, Ottawa 2

October, 1961

A. SUMMARY

Very shortly after Newfoundland became a province of Canada plans for obtaining Victorian Order service were begun. Two branches were organized, one in St. John's in 1952 and in the following year, one in Corner Brook. These branches serve 25% of the total population of the island. It was through the voluntary efforts of local service clubs that interest in Victorian Order service was initiated and this voluntary support has been continued on the part of board members who give generously of their time and efforts in promoting the aims of the Order.

The existing facilities for public health nursing services varied considerably in Newfoundland and so Victorian Order programs are quite different in the two branches. They were planned to provide needed service and to avoid duplication or overlapping with other agencies. In this regard it is of note that St. John's is the only Victorian Order branch in Canada which does not provide home nursing care for indigent patients.

Although at various times there has been considerable interest in securing Victorian Order service

to the

ROYAL COMMISSION ON HEALTH SERVICES

THE VICTORIAN ORDER OF NURSES FOR CANADA

ON BEHALF OF ITS BRANCHES IN NEWFOUNDLAND

5 Blackburn Avenue, Ottawa 2

October, 1961

(A) [illegible]

Very shortly after Newfoundland became a province of Canada plans for obtaining Victorian Order service were begun. Two branches were organized, one in St. John's in 1952 and in the following year, one in Corner Brook. These branches serve 25% of the total population of the island. It was through the voluntary efforts of local service clubs that interest in Victorian Order service was initiated and this voluntary support has been continued on the part of board members who give generously of their time and efforts in promoting the aims of the Order.

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Although at various times there has been

for other areas in the province, it has been difficult to secure the necessary financial support. This is mainly because in many instances the community is too small to support a voluntary agency and being isolated is not able to be combined with other areas.

The policies and programs are flexible and are set up to meet a community's needs. The Order is vitally interested in participating in any plans to provide service to as many people in Newfoundland as possible provided means of financing can be found and duplication of service avoided.

B. PRESENT FACILITIES

1. Area Served

The two branches of the Victorian Order of Nurses in Newfoundland provide nursing care and health supervision in St. John's and Corner Brook. These two branches serve an estimated population of 113,694 or 25% of the total population of the island. (Population figures for St. John's and Corner Brook were obtained from the preliminary count of 1961 census and for Newfoundland from estimated population as of March 1, 1961)

2. Development of Services

It was in 1950, shortly after Newfoundland became a province of Canada, that the first enquiries about the possibility of Victorian Order service were received at the national headquarters in Ottawa. As a result of these enquiries, officials of the Order went to Newfoundland and worked out with the authorities there, plans for the development of Victorian Order service. It was pointed out to the Order that there was a need

for other areas in the province, it has been difficult to secure the necessary financial support. This is mainly because in many instances the community is too small to support a voluntary agency and being isolated is not able to be combined with other areas.

The policies and programs are flexible and are set up to meet a community's needs. The Order is vitally interested in participating in any plans to provide service to as many people in Newfoundland as possible provided means of financing can be found and duplication of service avoided.

1. Area Served

The two branches of the Victorian Order of Nurses in Newfoundland provide nursing care and health supervision in St. John's and Corner Brook. These two branches serve an estimated population of 115,634 or 25% of the total population of the island. (Population figures for St. John's and Corner Brook were obtained from the preliminary count of 1951 census and for Newfoundland from estimated population as of March 1, 1951)

2. Development of Services

It was in 1950, shortly after Newfoundland became a province of Canada, that the first enquiries about the possibility of Victorian Order service were received at the national headquarters in Ottawa. As a result of these enquiries, officials of the Order went to Newfoundland and worked out with the authorities there, plans for the development of Victorian Order service. It was pointed out to the Order that there was a need

for part-time nursing services at home as there were many people who did not want charity but who could not afford prolonged hospitalization or private nursing costs. Their only alternative was to incur a crippling financial burden or do without vital attention.

There were a variety of services given to the people of Newfoundland. Many were available through the facilities of the provincial Departments of Health and Welfare, others were provided by voluntary organizations. Some of the voluntary groups were partially subsidized by government. The aim of the Order was to bridge the wide gap then existing in these health services without overlapping or duplication. From the beginning these plans had the support of the provincial Department of Health, hospitals, doctors, nurses and health societies of various types.

With the financial help of the St. John's Rotary Club and the Corner Brook Lion's Club, the services of Victorian Order nurses were inaugurated first in the City of St. John's in 1952 and in Corner Brook the following year.

3. Organization

Service club backing was the spark that kindled interest in the formation of the two branches. This support continued throughout the early years of development and was gradually withdrawn as others were prepared to take over.

From the beginning, the affairs of each branch were the responsibility of a board of management, made up of public-spirited men and women of the community

There were a variety of services given to the people of Newfoundland. Many were available through the facilities of the provincial Departments of Health and

Some of the voluntary groups were partially subsidized by government. The aim of the order was to bridge the gaps they were striving in their health services without overlapping or duplication. From the beginning these groups had the support of the provincial Departments of Health, municipalities, towns, nurses and health societies of various types.

Thus out the Corner Brook Medical Clinic, the services of Grenfell Order nurses were inaugurated here in the city of St. John's in 1921 and in Corner Brook the following year.

Service such activity was the spark that kindled interest in the formation of the two societies. Lack support, insufficient understanding in early years of activity meant all was practically withdrawn as others were prepared to take over.

From the beginning, the aims of each branch were the responsibility of a board of management, made

elected at the annual meetings. These members serve in a voluntary capacity and their enthusiasm and energy is vital to any plans for expansion of service. The voluntary members of the board serve on committees which deal with finances, publicity and the general operation of the branch. In each branch a medical advisory committee consisting of two to three local doctors, act in a consultant role to the nursing staff on medical matters. The continuing support of the medical profession is evident, especially in Corner Brook, as several local doctors there have served on the board in various capacities including the office of president.

Although both branches are incorporated, a provincial organization has not yet been formed. This may be accounted for by the fact that the two branches in Newfoundland are widely separated one from the other. Difficulty would be encountered in getting together for joint meetings.

4. Program

The program given in the two branches in Newfoundland differs because the needs of the community determine what service will be given by the Victorian Order. For instance, in St. John's the official agency provided nursing care at home to indigents and the Child WelfareAssociation offered health supervision to infants and young children. Consequently the Victorian Order has developed a program which was designed primarily to meet the needs of those people who are ill at home and who can afford to pay for care. Another group requiring services were new mothers on their return from hospital.

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[illegible] union a medical advisory committee consisting of two to three local doctors, not in a consultant role to the nursing staff on medical matters. The continuous support of the medical profession [illegible]

[illegible] opposition during the office of president.

Although both medical [illegible] are incorporated, a provincial organization has not yet been formed. This [illegible] in Newfoundland are similarly separated one from another. Difficulty would be encountered in getting a quorum for joint meetings.

The program given in the two remaining in Newfoundland differs because the needs of the community determine what a service will be given by the Victorian Order. For instance, in St. John's the official agency provides nursing care at home to immigrants and the child welfare association carried health supervision to infants and young children. Consequently the Victorian Order has developed a program that was designed primarily to

Care and instruction is available to these mothers particularly those who require demonstrations in newborn care. The majority of maternity and newborn patients are now being discharged from hospital within three days because of the need for hospital beds.

The situation in Corner Brook was quite different. There were few public health nurses working in the area and at the request of the provincial Department of Health, school health services were given. This was in addition to home visiting which included visits for both nursing care and health supervision. The Department of Welfare paid the Order for nursing care to indigent patients. Just recently the provincial Department of Health has appointed a regional medical officer for the Corner Brook area. The local branch is glad to co-operate with him in planning programs and have agreed, at his request, to visit all new babies as soon as possible after discharge from hospital.

In 1960 in the two branches in Newfoundland, a total of 9,121 visits were made to 1,094 patients, an increase over the previous year of 8% in visits. An analysis of the service shows that 52% of the cases admitted were medical and surgical patients, the remaining 48% maternity and newborn. 62% of the visits were made to medical and surgical patients, 19% to maternity and newborn and 14% for other health supervision. More detailed statistical information is given in Appendix 1.

Close contact is maintained with the hospitals in the areas served to facilitate a continuity of service to those medical and surgical patients being

[illegible]

[illegible] The reporting of maternity and newborn patients [illegible] being discharged from hospital within three days [illegible]

The situation in Downer Beach was quite different. There were few public health nurses working in the area and at the request of the provincial Department of Health, school health services were given. This [illegible]

for bedside nursing care and health supervision. The Department of Welfare paid the cost for nursing care to indigent patients. Once notified the provincial Department of Health has appointed a rural medical officer for the Downer Beach area. The local branch is glad to cooperate with him in planning services and have agreed, at his request, to visit all new babies as soon as possible after discharge from hospital.

In 1946 in the two townships in Wentworthland, a total of [illegible] visits were made to [illegible] patients, an increase over the previous year of [illegible] in visits. An analysis of the services shows that [illegible] of the nursing visits were medical and surgical patients, the remaining for maternity and newborn. [illegible] of the visits were made to medical and surgical patients, [illegible] to maternity and newborn, and [illegible] under health supervision. More detailed comparative information is given in Appendix I.

These contact is maintained with the hospitals in the areas served to facilitate a continuity of [illegible]

discharged and still needing nursing care and health supervision. In 1960 one-quarter or 27.4% of all medical and surgical patients admitted by the Order had come from a hospital. There is no formal plan for this but these cases were referred by either hospital staff or family doctor. The setting up of referral programs is being studied to assist in this transfer of the patient from hospital to home care.

5. Personnel

The two branches employ six nurses, three in each branch. Of the six nurses employed, three have qualifications in public health nursing. These three nurses received bursaries from the Victorian Order of Nurses for Canada to assist them in obtaining preparation in public health nursing at university. Relief nurses are used during vacation period and when the demands for service require additional assistance. This ensures service at all times including week-ends.

In-service education and staff conferences are important to keep the nursing staff informed and aware of new trends in nursing activities. The nurses are encouraged to attend referesher courses and institutes when they are available.

In 1961 arrangements were made between the School of Nursing, Dalhousie University and the branches in Newfoundland for public health nursing students to receive a three week field experience. Last year twenty-eight students from hospital schools of nursing spent a day observing Victorian Order nursing in the St. John's branch.

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The two bureaus employ six nurses, three in each bureau. If the six nurses employed, three may qualify sanitarians in public health nursing. These three nurses are over burdened from the Victorian Order of Nurses for Canada to assist them in obtaining preparation in public health nursing at university. Rural nurses are used during vacation periods and when the demand for service requires additional assistance. Three nurses survive at air force employing workmen.

Important to note the nursing staff interest and energy of new teachers in nursing activities. The nurses are encouraged to attend conferences, courses and institutes when these are available.

School of nursing, Victoria Hospital, and the Bureaus in the Municipality for public action increasing students to

6. Office, Telephone and Transportation

It is the responsibility of the board to maintain a suitable office with the appropriate equipment - records, files, etc., and the necessary nursing supplies. One branch has the use of an office rent-free while the other pays rent in an office building.

Because of the nature of Victorian Order service some provision must be made for the telephone to be answered at all times. In St. John's the Victorian Order is indebted to the Police Department which covers the service for the twenty-four hour period. In Corner Brook calls are taken by the Department of Health during the day and by the local hospital at night and on week-ends.

Adequate transportation not only saves time but also conserves the nurse's energy for nursing care. Each branch operates three cars.

7. Finances

In 1960 $31,941.00 was raised to support Victorian Order service in Newfoundland. This was done in the following ways -

(a) The provincial Department of Health furnished a grant of $7,250. or 22.7% of the total provincial income. This grant is paid to the Corner Brook branch for service given to the schools there and meets 41.6% of the total revenue received by Corner Brook.

(b) Money received from nursing fees totalled 39.7% of all income. On a branch basis there is wide variation here too. In St. John's where the program is concerned almost entirely with

[illegible]

[illegible]

Because of the nature of Victorian Order nursing care provision must be made for the telephone to be answered at all times. In Mr. Jean's the Victorian Order is housed in the Public Department which covers the service for the Great Victoria Lake Region. In Corner Brook calls are taken in the Department of Health during the day and by the local hospital at night and on week-ends.

Miscellaneous transportation not only saves time but also conserves the nurse's energy for nursing care.

In 1950 $14,500.00 was raised to support Victorian Order nurses in Newfoundland. This was done in the following ways -

(a) The provincial Department of Health furnished a grant of $7,250. or 22.1% of the total provincial income. This grant is paid to the Corner Brook branch for service given to the schools there and meets 41.5% of the total revenue received by Corner Brook.

(b) Money received from nursing fees totalled 29.7% of all income. On a branch basis there is [illegible] the program is concerned almost entirely

the care of the sick at home, 48.7% of total branch revenue came from this source. In Corner Brook 32.3% of total income was received direct from patients.

(c) The remaining amount, 37.6% of the provincial total was raised by appeals to the public. On the local level, 51.3% of income in St. John's came from local appeals for funds. In Corner Brook only 26.1% of branch revenue comes from this source.

No municipal grant is received by either branch.

Total disbursements in 1960 amounted to $32,174. The largest item included in this amount was salaries which amounted to 59% of the total. Ohter amounts were transportation and related expenses - 32%; office supplies and upkeep 4%; and general expenses, including nursing supplies, insurance, pension contributions - 5%. The rather high percentage for transportation is partly due to car purchases in both branches.

C FACTORS INFLUENCING VICTORIAN ORDER SERVICE

Requirements for ogranization and operation of a branch of the Order are a need for visiting nursing service and the funds required to support it. On more than one occasion requests have been received from people in various communities in Newfoundland, who are interested in having Victorian Order nursing service established. These include Stephenville, Grand Falls, Bishop Falls, Bell Island and more recently Deer Lake. In all these areas the chief obstacle to organization is a financial one. There is an acknowledged need for

service but difficulty is encountered in determining where sufficient money will come from to finance the service on a continuing basis.

A factor contributing to the difficulty in obtaining funds is the size of the areas concerned. Often the communities are isolated areas and there are not enough people there from whom money can be drawn to support a voluntary agency. As more industry goes into the areas or the general economy improves, there may be more hope for financial support.

It is currently apparent that the provision of nursing care in the home plays an important role in the total care of the sick. As a voluntary agency with flexible policies and programs, the order is vitally interested in participating in any plans to provide such service to as many residents of Newfoundland as it possibly can, provided means of financing can be found and duplication of service can be avoided.

APPENDIX I

Statistical Analysis of Visiting Nursing Service

The two methods of obtaining statistical information has been described in the preliminary statement submitted by the Victorian Order of Nurses for Canada. The following analyses are based on selected data compiled by both methods for the year 1960. The data quoted from the Dominion Bureau of Statistics for 1960 are preliminary and have not yet been published. In 1960 in the two branches in Newfoundland 9,121 visits were made to 1,094 patients. Patients were almost equally divided between mothers and babies (48%) and those admitted for illness or health counselling (medical and surgical 52%). Only 19% of all visits were made to mothers and newborn babies while 62% were made to patients with medical or surgical conditions. 14% of all visits were made for health counselling, the majority being to infants, pre-school and school age children. Table I indicates data relating to this analysis.

TABLE I

NUMBER OF CASES AND VISITS BY TYPE IN 1960

TYPE	CASES	%	VISITS	%
Maternity and Newborn (1)	528	48	1,686	19
Medical and Surgical	566	52	5,840	62
Health Instruction			1,128	14
Infant			554)	
Preschool			35)	(8.2)
School			155)	
Adult			384	
Other Visits (2)			467	5
TOTAL	1,094	100	9,121	100

(1) Newborn: age 28 days or less. Visits include 511 for health instruction.

(2) Patients not seen. On behalf of patient

Source: Victorian Order of Nurses for Canada, Branch Statistics 1960

The two methods of obtaining statistical information has been described in the preliminary statement submitted by the Victorian Order of Nurses for Canada. The following analyses are based on selected data compiled

nurses of statistics for 1960 are preliminary and have not yet been published. In 1960 in the two branches in Newfoundland 9,121 visits were

mothers and babies (46%) and those admitted for illness or health counselling (medical and surgical 12%). Only 1% of all visits were made to mothers and newborn babies while 61% were made to patients with medical or surgical conditions. 14% of all visits were made for health counselling, the majority being to infants, pre-school and school age children. Table I indicates data relating to this analysis.

TABLE I

NUMBER OF CASES AND VISITS BY TYPE IN 1960

TYPE	CASES	%	VISITS
Maternity and Newborn (1)	509	46	1,486
Medical and Surgical	564	52	5,394
Infant			
School			
Adult			344
[illegible]			[illegible]
TOTAL	1,094	100	9,121

1) Newborns age 28 days or less. Visits include 311 for health instruction.

(2) Mothers not seen. On behalf of patient

Source: Victorian Order of Nurses for Canada, Branch Statistics 1960

From data compiled by the Dominion Bureau of Statistics on cases dismissed by the Victorian Order of Nurses in Newfoundland in 1960, information is available regarding the age groups of patients receiving care and the cause and duration of illness. Table II shows that patients with medical and surgical conditions numbered 491 and received 6,722 visits. Service was given for as short a period as one day or extended over several years. The majority of these patients (78.5%) received care for less than 1 month. However, 49% of the visits were to patients who received care for more than one year.

TABLE II

NUMBER OF DISMISSED CASES AND VISITS BY DURATION OF NURSING SERVICE

DURATION OF NURSING SERVICE	CASES		VISITS	
	Number	%	Number	%
Under 1 month	386	78.5	1,074	16
1 month to 3 months	65	13.2	704	10.5
3 months to 1 year	32	6.5	1,652	24.5
1 year and over	8	1.8	3,292	49
TOTAL	491	100	6,722	100

Source: Dominion Bureau of Statistics from medical and surgical cases dismissed by the Victorian Order of Nurses for Canada in 1960.

27.4% of all medical and surgical patients were admitted after discharge from hospital and they received 25.9% of the total visits.

compiled by the Dominion Bureau of Statistics on cases dismissed from the Victorian Order of Nurses in Newfoundland in 1950, information is available regarding the age group of patients receiving care and the cause and duration of illness. Table II shows that patients with medical and surgical conditions numbered 491 and received 6,722 visits. Care was given for as short a period as one day or extended over several years. The majority of these patients (78.3%) received care for less than 1 month. However, 40% of the visits were to patients who received care for more than one year.

NUMBER OF DISMISSED CASES AND VISITS BY

DURATION OF NURSING SERVICE

DURATION OF	CASES	VISITS
Under 1 month		
1 month to 3 months		
3 months to 1 year		
1 year and over		
TOTAL		

Source: Dominion Bureau of Statistics from medical and surgical cases dismissed by the Victorian Order of Nurses for Canada in 1950.

27.4% of all medical and surgical patients were admitted after discharge from hospital and they received 25.2% of the total visits.

Table III shows that almost 71% of all medical and surgical patients dismissed from care in 1960, were either under 15 years of age or over 65. Patients in the older age group accounted for 68.1% of the visits.

TABLE III

DISTRIBUTION OF MEDICAL AND SURGICAL CASES AND VISITS BY AGE

AGE	CASES		VISITS	
	Number	%	Number	%
Under 15 years	187	38	327	4.9
15 - 44	84	17.1	562	8.4
45 - 64	59	12	1,254	18.6
65 and over	162	32.9	4,579	68.1
TOTAL	491	100	6,722	100

Source: Dominion Bureau of Statistics from medical and surgical cases dismissed by the Victorian Order of Nurses for Canada in 1960

The cause of illness has been classified by 25 cause groups in accordance with the standard groupings listed in the International Classification of Diseases, Injuries and Deaths (1955 Revision). In relation to cause of illness, almost half (48%) of all medical and surgical patients were found in the eight cause groups which could be considered to be mainly chronic illness. Over three-quarters of all visits to medical and surgical patients (76.4%) were to patients in these cause groups. Service was required by 174 patients (45%) for less than one month. Less than 2% of all medical and surgical patients required service for more than 1 year but they received almost half the total visits (45.8%) Table IV on the following page gives this information.

patients in the older age group accounted for 68.1% of the visits.

DISTRIBUTION OF MEDICAL AND SURGICAL CASES

AND VISITS BY AGE

Under 15 years	167	38	
15 - 44	84	17.1	
45 - 64	59	12	
[illegible]	[illegible]	[illegible]	
TOTAL	491	100	

Source: Dominion Bureau of Statistics from medical and surgical cases dismissed by the Alberta Order of Nurses for Canada in 1966

The cause of illness has been classified by 25 cause groups in accordance with the standard Abridged Lists in the International Classification of Diseases, Injuries and Deaths (1965 Revision). In relation to cause of illness, almost half (48%) of all medical and surgical patients were found in the eight cause groups which could be considered to be mainly chronic illness. Over three-quarters of all visits to medical and surgical patients (76.4%) were by patients in these cause groups. Service was required by 174 patients (68%) for less than one month. Less than 7% of all medical and surgical patients required service for more than 1 year but they received almost half the total visits (45.8%) Table IV on following page gives this information.

TABLE IV

DURATION OF NURSING SERVICE FOR 8 CAUSES OF ILLNESS (CHRONIC) BY CASES AND VISITS

CAUSES	UNDER 1 MONTH		1 MONTH UNDER 1 YEAR		1 YEAR AND UNDER 2		2 YEARS AND UNDER 3		3 YEARS AND OVER		TOTAL	
	Cases	Visits	Cases	Visits	Cases	Visits	Cases	Visits	Cases	Visits	Cases	Visits
All Causes	386	1,074	97	2,356	3	557	3	483	2	2,252	491	6,722
Malignant Neoplasms	22	114	12	336	-	-	-	-	-	-	34	450
Diabetes	6	18	3	74	-	-	-	-	-	-	9	92
Anemias	3	5	2	11	-	-	-	-	-	-	5	16
Central Nervous System	85	175	19	853	1	184	1	272	1	1,787	107	3,271
Diseases of Heart	17	71	6	126	1	316	-	-	1	465	25	978
Other diseases of Circulatory System	5	25	5	169	1	57	-	-	-	-	11	251
Arthritis & Rheumatism	5	44	1	17	-	-	-	-	-	-	6	61
Senility, symptoms ill-defined conditions	31	89	8	66	-	-	-	-	-	-	39	155
TOTAL	174	541	56	1,652	3	557	1	272	2	2,252	236	5,274

Source: Dominion Bureau of Statistics from medical and surgical cases dismissed by the Victorian Order of Nurses for Canada in 1960.

| | | |

APPENDIX II

1. SUMMARY OF GENERAL RECEIPTS FOR THE YEAR 1960 IN NEWFOUNDLAND

RECEIPTS	NEWFOUNDLAND	CORNER BROOK	ST. JOHN'S
NURSING FEES			
Patients	$9,692.00	$3,834.00	$5,858.00
Other (1)	3,003.00	1,800.00	1,203.00
GRANTS			
Municipal	-	-	-
Provincial	7,250.00	7,250.00	-
COMMUNITY APPEALS			
Community Chest	-	-	-
Branch Campaigns	11,046.00	4,011.00	7,035.00
MISCELLANEOUS			
Donations, gifts, etc.	950.00	*550.00	*400.00
TOTAL RECEIPTS	$31,941.00	$17,445.00	$14,496.00

(1) Other includes payment from contracts with Department of Veterans' Affairs and Insurance Companies.

* Sale of Car.

ITEM	MINROUMEIANO	CORNER BROOK	ST. JOHN'S
MUNICIPAL FUNDS			
Patients	$5,692.00	$3,834.00	$5,858.00
Other (1)	3,003.00	3,800.00	1,703.00
GRANTS			
Municipal	-	-	-
COMMUNITY AGENCIES			
Community Chest	-	-	-
MISCELLANEOUS			
Donations			
TOTAL FUNDS	$31,961.00	$17,445.00	$14,436.00

(1) Often includes payment from contracts with Department of Veterans' Affairs and Insurance Companies.

* Data of 2.00.

2. SUMMARY OF GENERAL DISBURSEMENTS FOR THE YEAR 1960 IN NEWFOUNDLAND

DISBURSEMENTS	NEWFOUNDLAND	CORNER BROOK	ST. JOHN'S
Salaries (before tax and other deductions)			
Nursing Staff	$19,036.00	$9,068.00	$9,968.00
Transportation Expenses	2,539.00	996.00	1,543.00
Rent & Related Expenses	900.00	900.00	-
Nursing Supplies & Equipment	140.00	71.00	69.00
Office Expenses (1)	392.00	159.00	233.00
General Expenses (2)	1,385.00	707.00	678.00
Miscellaneous Expenses	60.00	-	60.00
Capital Disbursements:			
Automobile purchase payments	7,722.00	6,448.00	1,274.00
TOTAL DISBURSEMENTS	$32,174.00	$18,349.00	$13,825.00

(1) Among items included under Office Expenses are the following; Express; Inspection and Repair, Office Equipment; Nursing Forms and Records; Postage; Printing and Stationery; Telephone and Telegraph (including answering service).

(2) Among items included under General Expenses are the following: Advertising and Publicity; Annual Meeting Expenses; Auditing, Bank Charges and Exchange; Dues and Subscriptions; Insurance - Staff accident, sickness - Employers' Liability, Workmen's Compensation, etc; Laundry; National Professional Service Charge; Nurses Health Examination; Post Office Safety Deposit Boxes; Refresher Courses; Pension Plan - Branch Contributions; Uniform Allowance.

		COMMON BROOK	ST. JOHNS
Salaries (before tax and other deductions)			
Average Staff	$10,084.00	-	
Transportation Expenses	2,549.00	996.00	1,513.00
Rent & Related Expenses	500.00	200.00	
Meeting Supplies & Equipment	180.00	71.00	50.00
Office Expenses (1)	397.00	159.00	83.00
General Expenses (2)	1,396.00	707.00	578.00
Miscellaneous Expenses	50.00	-	50.00
Capital Disbursements:			
Automobile purchase payments	7,722.00	6,148.00	1,274.00
TOTAL OPERATING SUMMARY	32,171.00	$18,387.00	$13,237.00

(1) Among items included under Office Expenses are the following Expenses: Insection and Repair, Office Equipment; Heating from and Cleaning Factory; Printing and Stationery; Telephone and Telegraph (including answering service).

(2) Among items included under General Expenses are the following: [illegible] Conveyor and Exchange; Dues and Subscriptions; Insurance - Staff Pension; Stamps - Employers' Liability, Workmen's Compensation; [illegible] n Plan - Employer Contributions; Uniform Allowance.

THE CHAIRMAN: Thank you, Mrs. Botham.

Any questions, Dr. Baltzan?

COMMISSIONER BALTZAN: Perhaps just one thing. Is this an exception that indigent patients are not served here, an exception to the rule compared with elsewhere?

MRS. BOTHAM: I think that is covered by our Department of Public Welfare to some extent, so we can't overlap the agency services.

COMMISSIONER BALTZAN: I take it that it is not that you are not giving that attention; the other people are being taken care of.

MRS. BOTHAM: Yes.

COMMISSIONER BALTZAN: That is all, Mr. Chairman.

COMMISSIONER GIRARD: Mr. Chairman, I think I had a comment to make, but I don't think it is fair to make it because it concerns the Government people who have just left, and the V.O.N. national office is not here or Miss Leask either. But I was wondering at the moment, since there is a great shortage of nurses in Newfoundland, and since the Victorian Order of Nurses does not take care of indigents, I believe it is easier for the Victorian Order of Nurses, because of their scholarship program, to bring in nurses from other Provinces, because the nurses on scholarships must go where the Order feels there is the greatest need. It may be easy to find out from the V.O.N. national office and from the Government if they could bring in more nurses, and if arrangements could be made for the Government to take care of indigents it would

make more nurses available.

DR. McGRATH: We would be very glad indeed if the Victorian Order of Nurses could supply more nurses. The Government would be very glad to pay for their services.

COMMISSIONER GIRARD: I know that through their scholarship program they can send more nurses; I know that they have sent nurses to Nova Scotia through that system, and that could probably be done here also. But we are looking to all the possibilities when we are looking at the shortage of nurses throughout Canada, not only in Newfoundland.

COMMISSIONER BALTZAN: For the record, if I may just add one word. Would you in your supplementary brief add on for clarification so that it may complete the matter in regard to your last statement about indigent patients.

THE CHAIRMAN: It is in paragraph 4.

MISS WALL: It is only in the St. John's Branch that we do not give service to the indigents. In the Cornerbrook Branch, where there are no department nurses we do give care to the indigent patients, and if they are welfare patients, the visits are paid by the Department of Welfare. St. John's is the only branch where this arrangement is made, but it was because when the Victorian Order Branch was started in St. John's, care of indigents was already being given.

If I could just speak in regard to nurses. The Victorian Order also has difficulty recruiting staff, but our system of bursaries is certainly a help, and we

have had the advantage of being able to send nurses to various Provinces. Of our six nurses in Newfoundland, three have been recruited locally and the other three have been nurses who have accepted bursaries and have been sent to the branches here and have remained over a period of two or three years. We do have the advantage of being able to recruit nationally, and I know we can continue. We have had difficulty at times in getting staff, but at the moment we are able to fill the positions.

DR. McGRATH: I would like to correct a small error. I think that reference was to the Department of Welfare supplying nurses. Actually it is the Department of Health supplies nurses.

COMMISSIONER GIRARD: Would you consider both the V.O.N. in this capacity in letting us know, when you do send in some supplemental information, what are the possibilities of such a move?

DR. McGRATH: I think I can say right now that if it is possible for nurses to be supplied we would welcome them and make the necessary financial arrangements.

COMMISSIONER GIRARD: I know the V.O.N. would have to look into it very thoroughly.

DR. MILLER: If I may make a statement, my understanding is that V.O.N. has had considerable difficulty in getting enough nurses to carry on the work that it has been doing in Newfoundland so far.

MISS WALL: I think we have the same difficulty with other agencies in recruiting nurses, in recruiting prepared nurses. We recommend that our nurses have public health training. As I have just mentioned, only

three of the six have public health training. I think also the problem isn't only just supplying nurses; we have had several requests from other areas in Newfoundland about areas wanting Victorian Order service. There are other financial difficulties as well, providing the salary of the nurse, and I think it is quite true that we do have difficulty in recruiting staff, too, because of the isolation of the areas, and the difference in salary; this is one problem. We also have a disadvantage that the salary recommended in the different Provinces, there is a wide scale, and naturally the nurses are inclined to - girls who are in Newfoundland certainly like the area, but money and salary is a consideration, too, and we find with the very wide variation in salaries from one Province to another there is a shifting of the staffs.

COMMISSIONER GIRARD: Mr. Chairman, may I clarify the point I made. I did not mean nurses that came permanently with the V.O.N., I mean that the V.O.N. has nurses that are on bursary that served with the V.O.N. for one or two years and must be placed where the V.O.N. feels there is the biggest need, and I am thinking of these nurses who are still obligated to the V.O.N.

DR. MILLER: They apparently have not been available to Newfoundland.

MRS. BOTHAM: In Cornerbrook there is a branch of the V.O.N. and in St. John's where, if we have a vacancy for the Nurse in Charge, we immediately contact the national office and immediately we have the Nurse in Charge but if we required 10 or 20 nurses there would probably be a difficulty there. But I don't think there

[illegible] unfavorable conditions as well, providing the [illegible] of the nurses, and I think it is quite true that we [illegible] isolation of the areas, and the difference in a surgery where is one problem. We also have a disadvantage that the [illegible] while essay, and usually the nurses are inclined to - [illegible] who are in medical and surgical area, [illegible] with the very close relation to patients from one division [illegible] in a medical one or the surgical.

COMMANDER CLARK: Mr. Chairman, may I clarify the point I made. I did not mean nurses open [illegible] permanently on the V.O.N., I meant that the V.O.N. has [illegible] the use of nursing that served with the V.O.N. [illegible] for one or two years and must be placed where the V.O.N. [illegible] Army Nurse Corps, and I am thinking of [illegible] are still filtered by the V.O.N.

MR. MCCLEF: They generally have not been available on Nov[illegible].

MRS. [illegible]: In Washington there is a [illegible] a reserve for the Army Nurse Corps, we immediately contact the nurses. Offices and immediately we have the nurse in [illegible] but if we required 10 or 20 nurses there would [illegible]

is any problem in starting services if a community wishes it and if they can finance the nurse there.

THE CHAIRMAN: Your organization is basically a voluntary one.

MRS. BOTHAM: Yes.

THE CHAIRMAN: And you are dependent to a great measure on voluntary support for its continued operation?

MRS. BOTHAM: Yes; and it is basically for supplying the services that the Victorian Order of Nurses can provide. Basically it is to further the service of the Victorian Order and to try to fit in with the Government of the country in which the service operates.

THE CHAIRMAN: In that line of thought, I would like to put this to you, Mrs. Botham, and to Mr. Goodridge and Miss Harnett. On the assumption that there would be a comprehensive medical services program, can you visualize the function of the voluntary organization, continuance of the voluntary organization in a comprehensive medical services program, whatever the program might be?

MRS. BOTHAM: I think that our best end for service would be on a sort of comprehensive home nursing scheme.

THE CHAIRMAN: On a voluntary basis?

MRS. BOTHAM: No, but that would have to be, I think, partially ---

THE CHAIRMAN: I am not suggesting that you can give a complete answer at the moment. I suggest at the moment that perhaps you might give it serious thought,

MRS. FORBES: Yes; and it is peculiarly for
ding the veterans that the Victorian Order of Nurses
can provide. Sentiment is to further the service of
the Victorian Order and to pay so rich in with a Government
grant of the country to which the veterans responded.

THE CHAIRMAN: In their time of training, I
was in also in Great Britain in your, the Soldiers, and I know,
would be a compulsorily defined medicine program, and the
Victorian Order is not in the voluntary organization,
contribution to the military organization in a compulsory
state medical service program, whatever the program might
be.

MRS. FORBES: I don't think one need fear
service would be as a result of compulsorily been treating
soldiers.

THE CHAIRMAN: Or a voluntary basis?

THE CHAIRMAN: I am not suggesting that you
can give a complete answer at the moment. I suggest to
you that perhaps you might give it serious thought

because it is not only the Victorian Order of Nurses; there are many voluntary organizations in the health field, the Cancer Society, I can think of; there are a dozen of them, fifteen. Where are they going to fit into this idea of a comprehensive medical services plan for all Canadians in all Provinces and covering everybody? If you would care to think about it and then let us have your views in writing, we would be very grateful to you for them.

MRS. BOTHAM: Yes.

full dependence in all Provinces and covering everything.

If you would care to think about it and then let us have your views in writing, we would be very grateful to you

Yours sincerely,

[illegible]

COMMISSIONER FIRESTONE: I have two quick questions. Miss Wall, if more funds were available to cover your full budget in the Province, including expenses besides salaries, could you get more nurses for V.O.N., Newfoundland Chapter, from anywhere?

MISS WALL: I think that we would have, we couldn't get nurses in quantity.

COMMISSIONER FIRESTONE: But you could get more than you have now?

MISS WALL: I think that we could certainly attempt to, we have among our bursary nurses of last year we had, when we were able to give, intimate where they would like to work in Canada, I think it was three or four who said they would prefer the Atlantic Provinces. We certainly do not have an excess of applicants, but we could, I think, gradually build up our staff if the request came, if we were establishing branches.

COMMISSIONER FIRESTONE: I take it you have made available something like 25 nurses to Nova Scotia under this central plan, this is an approximate number, and after all, Newfoundland is almost the size of Nova Scotia population-wise, not quite, but almost. Should not there, in the interest of spreading nursing care more widely, a conscious and conscientious effort be made to provide more nursing services for a Province that needs it perhaps more than any other Province in Canada?

MISS WALL: Yes, I would like to just mention that the 25 nurses we have sent to Nova Scotia haven't always stayed, all of them have not stayed in Nova Scotia.

COMMISSIONER FIRESTONE: It is not a question

[illegible] nurses available, could you get more nurses for V.O.N.?

MRS. WARD: I guess that we would have, we

COMM. FITZGIBBON: But you could get

MRS. WARD: I think that we could certainly

[illegible] to, we have among our nursery nurses of last year

[illegible] we had, when we were also to give, training where they

would like to work in Canada, I think it was three or four

who said they would prefer the Atlantic Provinces, we

[illegible]

could, I think, gradually build up our staff if the demand

came, if we were establishing branches.

COMMISSIONER HUNSCHE: I take it you have

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under this central plan, that is an approximate number,

and after all, Newfoundland is almost the size of Nova

Scotia population-wise, not quite, but almost. Should not

there, in the interest of increasing nursing care more

widely, a coordinated and consistent effort be made to

provide more nursing services for a province that needs

it perhaps more than any other Province in Canada

[illegible]

that the 27 nurses we have sent to Nova Scotia haven't

always stayed, a lot of them have not stayed in Nova Scotia.

COMMISSIONER HUNSCHE: It is not a question

of staying, but it is a question of helping Nova Scotia for a temporary period, until other nurses are attracted and encouraged to stay there, so it is help on a temporary basis, so could a scheme not be developed to help Newfoundland on a temporary basis?

MISS WALL: I think our problem has been financial again. We have supplied the nurses, or at least the branches which are in existence have the staff that is needed at the moment. We have had interest in other areas, and in fact I am going to visit other areas, the Cornerbrook area, in the next few weeks. We have had requests from these areas about getting V.O.N. branches, but it has not come to the stage where we can recruit nurses, because of financial circumstances we have difficulty in raising the money in the locality.

COMMISSIONER FIRESTONE: But you heard what the Minister said. He said you come forward with proposals and we will foot the bill. Is that not enough encouragement to the ladies?

MISS WALL: We feel that the community has to have themselves encouragement, that the finances have to be raised in the community which is requesting V.O.N. service.

THE CHAIRMAN: Are you financed wholly on a Provincial basis?

MISS WALL: In Nova Scotia we are financed by Government grant.

THE CHAIRMAN: I appreciate that, but I mean does your system of financial, do you do it on a Provincial basis?

MISS WALL: I think our problem has been financial again. We have supplied the nurses, or at least our branches which are in existence have the staff that is needed at the moment. We have had interest in other areas, and in fact I am going to visit other areas, the commercial area, in the next few weeks. We have had requests from these areas about getting V.O.N. branches, but it has not come to the stage where we can provide nurses, because of financial circumstances we have difficulty in raising the money in the locality.

COMMISSIONER MACDONALD: Did you hear what the Minister said. He said you come forward with proposals and we will look the bill. Is that not enough encouragement to the ladies?

MISS WALL: We feel that the community has to have shown more encouragement, that the finances have to be raised in the community which is requesting V.O.N. services.

MRS CHALDNEY: Are you financed wholly on a provincial basis?

MISS WALL: In Nova Scotia we are financed by Government funds.

THE CHAIRMAN: I appreciate that, but I mean does your system of financing, do you do it on a provincial basis?

MISS WALL: It is on a branch basis. Each branch has its own campaign to raise funds.

COMMISSIONER FIRESTONE: Don't you think that the special circumstances in Newfoundland require a certain flexibility, as this brief suggests, and if this flexibility suggests that if the money coming from the Provincial Government should be used for the benefit of a locality, surely there is no harm in following such a flexible program?

MISS WALL: Certainly I am very glad to hear that the money may be forthcoming, and we will make every attempt to expand our services as much as we can.

COMMISSIONER FIRESTONE: Mrs. Botham, could you tell us if you have any evidence that the home care services provided by the V.O.N. reduced some of the pressure on the limited hospital services available in Newfoundland?

MRS. BOTHAM: I am afraid that I cannot say anything definite about that right off, because I have no means of assessing that, but I think that actually our branch in St. John's gives its services to more or less the chronically ill. I think it is 50% chronically ill, and the other 50% is taken up with others, but I think we do help patients to leave hospital a little earlier. I cannot tell how many, or what percentage that would cover. We could get that for you.

THE CHAIRMAN: At the foot of page 3, Mrs. Botham: "The majority of maternity and newborn patients are now being discharged from hospital within three days because of the need for hospital beds".

[illegible]

[illegible]

[illegible]

MRS. BOTHAM: Yes.

THE CHAIRMAN: Is it the inference that you are of help in that area?

MRS. BOTHAM: Well, we could be of help.

THE CHAIRMAN: I mean, are you in fact now?

MISS WALL: May I answer this? It is a little difficult for Mrs. Botham, because of the difference in program between the two branches. In St. John's, where the Department of Health and other agencies are doing largely the maternity and newborn service, our care in St. John's is more on a nursing care basis, whereas in Cornerbrook we have been asked by the Department of Health to visit all mothers and babies on return from hospital, and the service there is, a great deal of it, to the mothers and babies on return from hospital, but not so much in St. John's, and because they are returning home so early in their period after birth, we feel that we are, well, we have been asked by the Department to visit all mothers and babies, so that there must be a need for this type of care.

COMMISSIONER FIRESTONE: May I say thank you, Mrs. Botham, for offering to provide us with the information we require in a supplementary statement.

THE CHAIRMAN: Thank you very much. We will now adjourn until 2o'clock, when we will proceed with the submission of the Newfoundland Medical Association.

THE SECRETARY: This last submission will be known as Exhibit No. 22.

--- EXHIBIT NO. 22: Submission of the Victorian Order of Nurses for Canada on behalf of its Branches in Newfoundland

--- Luncheon adjournment

[illegible] Yes.

[illegible] Is the inference that [illegible]

[illegible]

MISS WATT: May I answer that? It is a [illegible]

[illegible] program between the two branches. In St. John's, where the Department of Health and other agencies are doing largely the maternity and newborn service, our case in St. John's is more a nursing care basis, disease in Conception Bay we have been asked by the Department of Health to visit all mothers and babies or return from hospital, and the service there is a great deal of it, to the mothers and babies a return from hospital, but not so much in St. John's, and because they are returning home so early in their [illegible] we feel that we are well, we have been asked by the Department to visit all mothers and babies, so that there must be a need for this type of case.

COMMISSIONER [illegible]: May I say thank you, Mrs. [illegible], for offering to provide us with the information we require in a supplementary submission.

VON CONFERENCE: Thank you very much. We will now adjourn until 2o o'clock, when we will proceed with the submission of the Newfoundland Medical Association.

THE SECRETARY: This last submission will be known as Exhibit No. [illegible].

--- EXHIBIT NO. 23: Submission of the Victorian Order of Nurses for Canada on behalf of the Province of Newfoundland

--- Luncheon adj.

--- On resuming at 2 p.m.

THE CHAIRMAN: We are now ready to go ahead with the submission of the Newfoundland Medical Association.

DR. TWOMEY: Mr. Chairman and members of the Royal Commission, distinguished guests, ladies and gentlemen: as President of the Newfoundland Division of the Canadian Medical Association, I wish to extend to you and the members of the Commission our sincerest greetings of welcome to our island Province. It is our hope and desire that during your visit here you will find it both pleasant and fruitful. We of the Newfoundland Division represent the majority of doctors in Newfoundland, and the views, opinions and conclusions expressed in the brief about to be submitted are those of the majority of our members.

Before introducing to you the Chairman of the Economics Committee, who will read the summary of the brief, may I say that if there is any further help or co-operation we can give you it will be given wholeheartedly and with our full feeling and pleasure.

I would like to introduce to you Dr. Baird who will be responsible for the reading of this brief. Any questions you may have, I hope you will direct to Dr. Baird, who in turn will direct them to members here present who are specialists in that particular field.

THE CHAIRMAN: Thank you very much.

SUBMISSION OF THE NEWFOUNDLAND MEDICAL ASSOCIATION

DOCTORS

SUBMISSION

to the

ROYAL COMMISSION ON HEALTH SERVICES

by the

NEWFOUNDLAND MEDICAL ASSOCIATION

Newfoundland Division of the Canadian Medical Association

O'Mara-Martin Building, Rawlins Cross, St. John's

November 2, 1961

Presented by:

Name	Address		
Dr. H.M. Twomey	Botwood	Gen. Practitioner	President N.M.A.
Dr. J. G. Williams	St. John's	Psychiatrist	1st. Vice President
Dr. M.G. Coxon	Gander	Gen. Practitioner	2nd Vice President
Dr. Eric Pike	St. John's	Pathologist	Honorary Sec'y
Dr.J.D.B.Baird	St.John's	Gen. Surgeon Chairman, N.M.A.	Honorary Treasurer & Economics Committee
Dr.F.L.O'Dea	St.John's	Obstetrician & Gynaecologist	Past-President
Dr. A.E.Shapter	St.John's	Orthopaedic Surgeon	Executive Com.
Dr.C.U.Henderson	St.John's	Anaesthetist	Executive Com.
Dr.A.R.Mercer	St.John's	Urologist	Executive Com. & Economics Committee
Dr.G.Battock	St.John's	Plastic Surgeon	Executive Com.
Dr. D.Cant	Corner Brook	Thoracic Surgeon	Executive Com. & Economics Committee
Dr. C.Avery	Bay Roberts	Gen. Practitioner	Executive Com.

2. Medical Organization

Name	Address		
Dr. H.M. Tumney	Pathologist	Gen. Medical Officer	Fort Louis N. [illegible]
[illegible]	[illegible]	[illegible]	[illegible] Prefecture
Dr. Enrico Ellis	St. Louis	Pathologist	Pharmacy Co. Ltd
Dr. J.D.H. Ellud	St. Louis	Gen. Surgeon, Anesthetist, X.R.A.	Hospital & Dispensary Surgeon & Dispensary consultant
Dr. F.L. Cuppa	St. Louis	Consultant Gynaecologist & Obstetrician	Maternity Hospital
Dr. A.E. Sawyer	St. Louis	Orthopaedic Surgeon	Executive Tob.
Dr. J.J. Jacobson	St. Louis	Microbiologist	Bacteria Co.
Dr. A.H. Moses	St. Louis	Dermatologist	Investigator Dermatologist
Dr. O. Malcolm	St. Louis	Private	Executive Tob.
[illegible]	[illegible]	[illegible]	[illegible] Committee
[illegible]	Gen.		Executive

Dr. C.J.Walsh	St. Lawrence	Gen. Practitioner	Executive Com.
Dr.R.O'Driscoll	Grand Falls	General Surgeon	Executive Com.
Dr.J.B. Roberts	St. John's	Internal Medicine	C.M.A.Executive.
Dr.P.J.Whelan	St. John's	General Surgeon	Public Relations & Economics Com.
Dr.B.J.Harley	Corner Brook	Internal Medicine	Economics Com..
Dr.G.Winsor	Corner Brook	Gen. Practitioner	Economics Com.
Dr.J.H. King	Corner Brook	Otolaryngologist	Economics Com.
Dr.E.J. Rix	Windsor	Gen. Practitioner	Economics Com.
Dr.H.J. Warrick	St. John's	Gen. Practitioner	Economics Com.
Dr.G.M.Brownrigg	St.John's	General Surgeon Chairman, Dept.ofSurgery, General Hospital. Chief of Surgery and Chairman of Medical Staff, St. Clare's Hospital	
Dr.Nigel Rusted	St.John's	General Surgeon Chief of Surgery and Chairman of Medical Staff, Grace Hospital.	
Dr.G.H.Flight	St.John's	Obstetrician and Gynaecologist President, St.John's Clinical Society	
Dr.H.D. Rosenberg	St.John's	Gen. Practitioner College of General Practice of Canada	Board of Representatives
Dr.T.G. Anderson	St.John's	Paediatrician	
Dr.C.H. Pottle	St.John's	Psychiatrist Mental Health Services, Dept. of Health	Director

Dr. E. A. MacLaughlin	St.John's Radiologist

-and-

Dr.A.D. Kelly	General Secretary, Canadian Medical Association, 150 St. George Street, Toronto 1, Ontario.

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SUMMARY OF RECOMMENDATIONS

Summary -

Health services in Newfoundland have developed more slowly than in other Provinces of Canada. Three main factors are responsible for this retarded growth"

(a) The policy of deliberate discouragement of colonization until the latter part of the eighteenth century;

(b) The long-continued dispute for sovereignty over large stretches of the Island, concluded only in 1920's, which hindered stable settlement along the south and west coasts;

(c) The relative poverty of Newfoundlanders who have enjoyed only brief periods of anything approaching prosperity in their history.

As a direct outgrowth of these conditions, the development of health services has differed from the pattern established in other Provinces of Canada. Lack of local economic self-sufficiency has brought about a heavy involvement of the central governing authority in the provision of hospitals and medical services, and a state of dependency which is unusual in Canada.

As a result, two of the most important health services, provided by the Provincial Government, are peculiar to Newfoundland - the Cottage Hospital Service providing hospitalization and medical services in the sparsely settled areas of the Province and the Children's Health Service which provides medical services in hospitals, at Government expense, for all children up

In Newfoundland have developed [illegible] many ways in other provinces of Canada. These [illegible]

(a) The policy of deliberate discouragement of colonization north the labber part of the [illegible] country;

(b) The long-continued dispute for ownership over large stretches of the Island, concluded only in 1960's, which hindered absolute [illegible] work along the south and west coasts;

(c) The relative poverty of Newfoundlanders who have enjoyed only brief periods of [illegible]

As a direct outgrowth of these conditions, the development of health services has differed from the pattern established in other Provinces of Canada. Lack of local economic self-sufficiency has brought about a heavy involvement of the central governing authority in the provision of hospitals and medical services, and a state of dependency which is unusual in Canada.

As a result, two of the most type that begins service, provided by the Provincial Government, are peculiar to Newfoundland - the Cottage Hospital Service providing hospitalization and medical services in the sparsely settled areas of the Province and the Outport Nursing Service which provides medical care

to age 16.

Thus Government has assumed a substantila interest in the amount and method of payment to Doctors. This has resulted in the development of a salaried service for Doctors working in the Cottage Hospital Service.

Although these Doctors formerly regarded themselves as physicians contracting with the Department of Health, a recent edict has classified them as civil servants who must sign and agree to an oath of secrecy.

The Cottage Hospital Service has been a necessary and effective means of providing medical services in outlying areas. It has not, however, provided a sufficient number of doctors to allow necessary improvements in the quality of medical care. Its continued existence in areas of improving economic status is, in our opinion, detrimental to patient care. These areas would be better served if conditions of private practice applied and to this end we are recommending a method of prepayment of the costs of medical services, with Government assistance.

Our lack of economic self-sufficiency is reflected in the acute shortage of hospital beds of all types and deficiencies in the new and necessary ancillary facilities and personnel. Recent decisions and commitments of our Provincial Government will ease these deficiencies in some areas. We are confident that Newfoundland will become more self-sufficient in the future if our circumstances continue to reflect the same rate of growth as we have experienced in the recent

pat.

However, today, our deficiencies in health services are many, our financial need is great, and we, the medical profession, cannot foresee that this Province can meet these needs from our existing financial resources. We would present, for your consideration, the following recommendations:

Recommendations

1. Medical Services Insurance - We believe that conditions of private practice will attract more doctors than a Government salaried service and thus will provide a better quality of care. We recommend that by a process of successive selection all areas of the Province should be encouraged to develop arrangements for the private practice of medicine in thier communities.

To assist in this endeavour it will be necessary for Governments to subsidize local voluntary plans for prepayment of the cost of medical services. The amount of such subsidy should be related to the economic circumstances of each area. (See pars. 81-88 and 114-115).

We would recommend for your consideration that the Federal and Provincial Governments should share the amount of subsidy necessary to implement these local plans for prepayment of the cost of medical services.

2. Mental Health Services - (Pars. 89-91, 104-106, 116-119)

Province can meet these needs from our existing financial resources. We would present, for your consideration, the following recommendations:

1. Medical Services Insurance - We believe that conditions of private practice will attract more well provide a better quality of care. We recommend that by a process of successive relaxation all areas of the Province should be encouraged to develop arrangements for the private practice of medicine to other communities.

To assist in this endeavour it will be necessary for Governments to subsidize local voluntary plans for prepayment of the cost of medical services. The amount of such subsidy should be related to the economic circumstances of each area. (See page. 91-88 and 114-115).

We will recommend to your consideration that the Federal and Provincial Governments should assume the amount of subsidy necessary to implement these local plans for prepayment of the cost of medical services.

Federal Health Services - (Pars. 89-91, 104-105, 116-

In Newfoundland 900 mental patients are being treated in one mental hospital, an annex and a psychiatric unit, all located in St. John's. Two hundred and fifty of these patients are being housed in accommodation which is below minimum standards. Using as a yardstick the modest total requirement for mental beds of 3.5 beds per thousand, we need an additional 1,000 beds for our present population.

Both facilities and personnel are in short supply so that we have been handicapped in implementing the tremendous new developments in the treatment of mental illness. We are advised that the additional 1,000 bed requirement should be implemented by building smaller hospitals of approximately 200 to 250 beds in St. John's, Corner Brook and Central Newfoundland, plus psychiatric units, up to 40 beds in size, in each of the larger general hospitals.

We do not believe that the resources of this Province are sufficient to provide these additional beds at this time. We are concerned that undue delay will prevent an early introduction of new methods of treating the mentally ill.

We, therefore, recommend for your consideration that the Federal Government should undertake to assume all, or almost all, costs of construction of new beds for the mentally ill. For Newfoundland we estimate that the total capital cost would be ten to twelve million dollars.

[illegible]

Two hundred and fifty of these patients are being [illegible]

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Both facilities and personnel are in short supply so that we have been handicapped in implementing the tremendous new developments in the treatment of mental illness. We are advised that the additional 1,000 bed requirement should be in addition to building smaller hospitals of approximately 200 to 250 beds in St. John's, Corner Brook and Gander. Meanwhile, plus psychiatric units, up to 40 beds in size, in each of the [illegible]

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The Federal Government should undertake to assume all, or almost all, costs of construction of new beds for the mentally ill. For Newfoundland we estimate that the total capital cost would be ten [illegible]

The erection of beds would, of course, increase the operating cost of the Provincial Mental Hospitals. The yearly increase would approximate 4.5 million dollars. We would, therefore, further recommend that the operating costs of mental hospitals be accepted by the Federal Government as shareable costs under The Hospital Insurance and Diagnostic Services Act.

3. Hospital Beds for the Acutely Ill, the Convalescent and the Chronically Ill

We have outlined deficiencies of 1,000 general hospital beds, 500 convalescent beds and 500 beds for the chronically ill. (paras. 99-103, 107,109). Of this number 500 general hospital beds will be built within the next few years and 125 convalescent beds will become available when the Pepperrell hospital is converted. Some easement in the requirement for general hospital beds may be realized when the additional beds for the convalescent and the chronically ill are provided.

It is likely, however, that the increase in hospital bed requirements consequent upon the natural population increase will offset these factotrs. We, therefore, must find, in the relatively near future $10,000,000 for the capital cost of additional general hospital beds and $8,750,000 for the construction of needed beds for the convalescent and chronically ill.

While we believe that our Province can finance these obligations over the long term (with the

[illegible]

[illegible] million dollars. We would, therefore, further recommend that the operating costs of such a hospitals be accepted by the Federal Government as chargeable costs under The Hospital Insurance and

2. Provided Beds for the Academic III, the General Service and the Chronically Ill

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It is likely, however, that the increase in hospital bed requirement consequent upon the rural population [illegible] will offset these losses. We, therefore, must find, in the relatively near future [illegible] for the capital cost of additional general hospital beds and $3,750,000 for the capital cost of needed beds for the convalescent

While we believe that our Province can finance

assistance of present Federal hospital grants), we consider that it is unlikely that funds can be made available at this time over and above the commitments for future hospital bed construction which have already been assumed.

We would, therefore, recommend that this Royal Commission study the possibility of establishing a Federal lending agency to assist in such construction with repayment of loans over a long term.

We would also recommend that consideration be given to the inclusion of depreciation of hospital buildings as a shareable cost, by the Federal and Provincial Governments, under the Hospital Insurance and Diagnostic Services Act.

4. Federal Health Grants

We have commented (paras. 59-61) that in the past these grants have been very helpful in assisting this Province to up-grade both the quality and quantity of health services in Newfoundland.

We recommend that the Commission study methods of extending these grants and augmenting the funds available so that this method of assisting the Provinces will continue to be as useful in the future.

5. Other Recommendations

In this submission we have made a number of additional recommendations which are primarily for the information of the Commission as implementation will result from continued discussions between our Association and the Provincial Government.

made available at this time over and above the commitments for future capital and construction which have already been assumed.

Commission study the possibility of establishing a Federal lending agency to assist in such consolidation with repayment of loans over a long term.

We would also recommend that consideration be given to the issuance of debenture bonds, bearing an a bearable cost, by the Federal and Provincial Governments, under the Hospital Insurance and Diagnostic Services Act.

We have commended (paras. 59-67) that in the past these grants have been very helpful in assisting Provinces to up-grade both the quality and quantity of health services in Newfoundland.

We recommend that the Commission study methods of extending these grants and augmenting the Fund - so that this method of assisting the Provinces will continue to be as useful in the future.

In this submission we have made a number of recommendations, [illegible] the implementation of the Commission as implementation [illegible]

These include:

(a) Rehabilitation (paras. 110-112)

There is a serious lack of rehabilitative facilities and personnel in Newfoundland. We recommend that rehabilitative beds and facilities be established in all larger hospitals in this Province. We would expect that this recommendation will be implemented concurrently with the fulfilment of the program we have outlined for needed beds for general hospital, mentally ill, convalescent and chronically ill patients.

(b) Ancillary Personnel (para. 94)

An improved health service for Newfoundland, which would apply if our recommendations are implemented, would urgently require an additional supply of nurses, radiological, laboratory and other technicians to man the improved and enlarged facilities. We believe that studies should be carried out to determine whether it would be possible for us to train a sufficient number of young Newfoundlanders in this Province to meet this future demand.

To this end, we recommend that nursing schools be established in Corner Brook and, subsequently, in Central Newfoundland and that the training of technicians required be undertaken through the Vocational School system now being established throughout the Province.

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Facilities be established in all large hospitals in this province. We would expect that this recommendation will be implemented concurrently with the fulfilment of the program we have outlined for needed beds in general hospital, mentally ill, convalescent and chronically ill patients.

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To this end, we recommend that nursing schools, especially, in Central Newfoundland and that it through the Vocational School system now being established throughout the Province.

(c) Professional Personnel (Paras. 92-93, 95-98)

The number of Doctors practising in Newfoundland has increased substantially in recent years. We believe that the increase would have been greater if conditions of private practice had prevailed throughout the Province. Particularly, we believe that under different circumstances of practice we would have retained a larger proportion of the imigrant physicians who have been attracted to Newfoundland from Britain and Ireland.

We believe that Newfoundlanders, particularly, could be attracted to service in our outlying communities. We would like to see more young Newfoundlanders studying medicine. Because of the heavy financial requirements of a course in medicine, we believe that this objective could be attained by the establishment of a medical school in St. John's and we recommend that consideration should be given to this possibility.

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Mr. Chairman and Members of the Royal Commission on Health Services:

1. The Newfoundland Medical Association, which is the Newfoundland Division of The Canadian Medical Association, is pleased to have an opportunity to present a submission which will highlight the peculiar and particular problems in the provision of health services which apply in Newfoundland.

2. Medical services in our Province have developed more slowly than in other Provinces of Canada. The reasons are rooted in the history of the Island, and its political and economic development.

3. The main factors which are responsible for this retarded growth are, first, the policy of deliberate discouragement of colonization until at least the latter part of the eighteenth centure; secondly, the long-continued dispute for sovereighnty over large stretches of the Island, concluded only in the 1920's, which hindered stable settlement along the south and west coasts in particular; and, finally, the relative poverty of our people who have enjoyed only brief periods of anything approaching prosperity throughout the whole extent of their history.

4. These factors have had unfortunate results in the development of health services and the evolution of medical practice. In only a relatively few areas have local conditions, either in the form of long standing settlement (St. John's) or of relative prosperity (Corner Brook and Grand Falls), permitted anything approaching organized medical care for the community.

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While it is true that a number of the larger fishing communities, especially in Conception and Trinity Bays, have always been served by a fair sprinkling of practitioners, the rest of the population, sparsely scattered in outlying districts, could only sustain isolated doctors, each with long stretches of coastline for his 'parish'.

5. As a direct outgrowth of these conditions, the development of medical services provided by private practitioners and by Government Agencies differed from the pattern established in other Provinces of Canada. The lack of local economic self- sufficiency brought about a heavy involvement of the central governing authority in the provision of medical services. This took the form of construction, or subsidy, of capital works (hospitals and like institutions) in those areas possessing a sizeable medical profession, and later, under the Commission of Government, a Government Agency became the exclusive employer of medical personnel, as well as the provider of facilities, in many areas remote from the large centres. This was the beginning of the Cottage Hospital Service.

6. These points are well illustrated by the few facts available regarding the practice of medicine in Newfoundland in its early days. The first record of a medical practicke and hospital, both probably military in nature, concerns the French Settlement of Placentia in the year 1662; the first mention of a qualified Medical Practitioner on the Island was in the year 1708 when a Surgeon to the Military Garrison in St.

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John's is recorded. In 1765 Drs. John Land and Clinch worked in Trinity, but the first wholly resident doctor on the Island is not found until 1784 when Dr. Johnathan Ogden practised in St. John's also as a Surgeon to the Garrison. For the remainder of the 18th Century, records mention a scattering of practitioners; Dr. Dingle practised in Bay Bulls in 1794, Drs. Duggan and McCurdy practised in St. John's in 1797, and about the same time Drs. Bradshaw, Mayde and Moore worked in outlying harbours. In 1808 Dr. William Carson arrived in Newfoundland and left his mark not only on the development of medical practice and institutions, but also figured prominently in the drive for local Government in this Province; he was dismissed from the post of Surgeon to the St. John's Volunteers in 1812 for writing a pamphlet agitating for Representative Government. No doctor was established on the disputed 'French Shore' (i.e. the entire West Coast) until 1880. It was not until 1902 that St. John's, the capital and main centre of population, appointed its first Medical Health Officer in the person of Dr. Brehm. In 1933 the Amurlee Commission found 62 doctors practising outside St. John's, none of whom were on the south coast west of Hermitage; the total medical population at this time was 104.

7. A further indication of the paucity of medical services and facilities is provided by the fact that in 1870 a redundant military hospital in St. John's was taken over by the Government and converted into a general hospital to serve the whole of Newfoundland, as

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it still does today; as late as 1893, at which time the population of the Island was over 200,000, it had no operating room, nor qualified nursing staff. In 1933 the only hospitals in existence outside St. John's were those of the Grenfell Mission in the far north and Labrador, the Notre Dame Bay Memorial Hospital at Twillingate, and the Company hospitals at Grand Falls and Corner Brook.

8. The continuing dependence on the Central Government for provision of health facilities and the substantial number of doctors now employed by Government on a contractural basis might suggest that the provision of medical services through government agencies was a traditional development. This is not so. Until the early 1930's, with minor exceptions, Newfoundland's medical services were provided privately by individual practitioners. Despite their small numbers and the difficulties under which they worked, individual members of the medical profession in Newfoundland have a proud history of pioneer work. In 1795 Dr. Clinch in Trinity, a former co-worker of Dr. Jenner, carried out the first vaccination programme in Newfoundland, and possibly in Canada, and his success had a decisive influence on the report of the Royal Commission on Vaccination in Great Britain. Upon the urging of Dr. Ogden, in 1795 military authorities built two military hospitals - the first such institutions in Newfoundland. Dr.William Carson made efforts to have a civilian hospital established shortly after his arrival, andhis efforts were crowned with success in 1813 when the

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Cadet, in 1795 military authorities built two military hospitals - the first such institutions in Newfoundland. Dr.William Carson made efforts to have a civilian hospital established shortly after his arrival, and his [illegible] were crowned with success in 1813 when the

foundation stone was laid; the cost of the completed hospital (just over two thousand pounds) was subscribed by the public. One of Carson's apprentices, Dr. Stabb, in 1845 succeeded in having the insane removed from the General Hospital to a separate house, and, as a result, in 1854 the central part of the present Mental Hospital was built. Dr. Renouf introduced anaesthesia in the 1840's; over the scepticism of his colleagues, he administered chloroform during the performance of an emergency tracheotomy.

9. In the 1880's Drs. Rendell, Stabb, Fraser and Kendell stimulated the practice of surgery as a result of their training in the principles of antisepsis in Edinburgh; later, Dr. Fraser opened a Children's Hospital, complete with an operating room, at his own expense. Dr. Smith of Burin, in 1892, carried out the first Ceasarean section in Newfoundland, again practising Lister's antiseptic methods. Dr. Wilfred Grenfell, with Dr. Cluny Macpherson, opened the first Grenfell Hospital in 1893, an all-year institution at Battle Harbour, Labrador, and a summer hospital at Indian Harbour. Dr. Herbert Rendell and one or two co-workers deserve renown for a gigantic step forward in the treatment of tuberculosis; convinced from their experience with private patients that open-air treatment in Newfoundland would be beneficial in spite of the climate, they began a small experimental sanatorium under the sponsorship of the Newfoundland Chapter of the Imperial Order of the Daughters of the Empire, with the result that the Government was con-

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vinced that sanatorium treatment was not only feasible but abolutely necessary. The Government subsequently embarked upon the erection of our present T.B. sanatoria.

10. In more recent times, individual doctors have brought almost the full range of modern medical science to Newfoundland - thoracic surgery, cardiology, paediatrics, neurosurgery, vascular surgery, radiotherapy, plastic surgery, ophthalmology and otolaryngology, radiology, neurology, endocrinology, etc. In many instances, these fields were pioneered in Newfoundland solely by the initiative of one or more individuals; in some cases, Government grants relieved some part of the burden in reaching these goals.

11. These Government subsidies are necessary in some instances because the private practice of medicine only applies to part of Newfoundland. In 1933, the Commission of Government initiated the Cottage Hospital Service to provide medical services in the sparsely populated areas of the Province.

This service has since grown to cover more than fifty percent of the total population and it involves directly the efforts of over sixty doctors at the present time. In the field of general medicine care, therefore, there has grown up in Newfoundland two distinct groups of physicians; on the one hand, those doctors still practising essentially as private practitioners in certain relatively circumscribed, though densely populated areas, and, on the other hand, those engaged in the Cottage Hospital Service and as Medical Health

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Officers under contract to the Provincial Department of Health.

12. The Cottage Hospital Service areas were gradually established from 1933 on; the remainder of the Province comprises the private practice areas. In 1961 the private practice areas are:

1. St. John's and surrounding area, including Manuels and Bell Island.
2. The Conception Bay area - Holyrood and Harbour Main, Avondale, Bay Roberts, Carbonear, Harbour Grace, Cupids and Brigus.
3. Trinity Bay area - Trinity, (but not including Western Bay, Hearts Content, etc.)
4. The Central area of Grand Falls, Biship's Falls, Buchans, Twillingate and Millertwon.
5. The West Coast area of Corner Brook, Curling and Deer Lake.
6. The Northern area of the Grenfell Mission, including St.Anthony, Battle Harbour, and Cartwright.

13. The population of these private practice areas is approximately 125,000. These persons are served in 1961 by 139 physicians in private practice - a ratio of one physician to approximately 900 persons. There are both general practitioners and specialists in most areas; the type and number of specialists in the Province are listed below:

7 Anaesthesiologists

8 Internists

1 Neurologist

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1. St. John's and surrounding area, including Manuels and Bell Island.
2. The Conception Bay area - Holyrood and Harbour Main, Avondale, Bay Roberts, Carbonear, Harbour Grace, Cupids and Placentia.
3. Trinity Bay area - Trinity, (but not including Western Bay, Hearts Content, etc.)
4. The Central area of Grand Falls, Bishop's [illegible]
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7 Anaesthesiologists

1 Neurosurgeon
2 Obstetricians and Gynaecologists
2 Ophthalmologists
5 Otolaryngologists
5 Orthopaedic Surgeons
5 Paediatricians
4 Pathologists
6 Psychiastrists
3 Radiologists
22 General Surgeons
1 Urologist

14. Most private practitioners, both general practitioners and specialists, work as solo practitioners. The geographic and economic reasons for this development in the outlying areas are obvious. In very large measure, Newfoundlandis not suited by reasons of geography for the development of group practice.

15. However, during recent years there has been a tendency for the formation of partnerships and small groups in the larger cities and town of the Province. These groups have been formed for the convenience of the doctors involved and to provide better service to their patients. In general, these groups are representative of doctors with similar interests rather than the diversified or clinic groups which are found in other parts of Canada and the United States.

16. The general practitioner as the family physician remains the back-bone of private practice. The development of specialist practice was in the main

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16. The general practitioner as the family

to develop a consultation and referral service for the problem cases encountered by the family physician. It also provides for the more efficient use of the special equipment necessary in modern medical treatment.

17. We believe that the success of private practice depends upon the maintenance of a good doctor-patient relationship. The basis of this relationship is the personal responsibility which the privately practising physician assumes in the treatment of his patients. In private practice the control over this relationship is exercised by the patient who is free to choose and to change his medical attendant.

18. There has been a noticeable tendency during recent years for the private practitioner to locate in the larger centres of the Province. While, this, no doubt, allows him to obtain such amenities as are available in the community for himself and his family, it is, as well, indicative of his desire to locate his practice in proximity to adequate medical facilities. The medical profession in Newfoundland strongly supports the right of the individual physician to choose the type and location of his practice. In our experience, the exercise of this right has not been in conflict with the public interest, but rather the increased facilities available, together with the improvements in transportation and communications, now allow the provision of a better quality of medical services without hardship to the patient. This is especially true in Newfoundland where the operation of the air ambulance service has been exemplary, and has allowed the provision

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of medical services which it would not otherwise be possible to provide.

19. In large measure private insurance can exist only in the private practice areas of the Province. Even in these areas, prepayment for the cost of medical services has not achieved a very substantial enrolment. In this we have differed from other Provinces of Canada forreasons which are perhaps peculiar to Newfoundland.

20. Only 59,000 Newfoundlanders are insured, in varying degrees, by private insurance carriers. In large measure, this represents the employees and dependents of organizations which have their head offices in other parts of Canada. They have continual employment and are employed in large groups. In this respect they differ from most Newfoundlanders.

21. The medical profession in Newfoundland believes that wider acceptance of the principles of prepayment for the cost of medical services is necessary for the further development of private practice in Newfoundland. We are aware of many of the inherent problems and in the concluding pages of this submission we make certain recommendations in this regard.

HEALTH SERVICES PROVIDED BY GOVERNMENTAL AGENCIES

22. The interest of Governments and Governmental Agencies in the provision of health services in Newfoundland is inherent in the descriptions which we have thus far portrayed. Prior to Confederation, the Commission of Government had introduced the Cottage

medical services which it would not otherwise be possible to provide.

19. In large measure private insurance can exist only in the private practice areas of the Province, even in these areas, prepayment for the cost of medical services has not achieved a very substantial enrolment. In this we have differed from other Provinces of Canada for reasons which are perhaps peculiar to Newfoundland.

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Hospital Service and had also implemented a number of public health services which are now the function of the Provincial Department of Health. Some services which are now provided through the Federal Government were previously the function of the Commission of Government; others, introduced subsequent to Confederation, are of more recent origin.

23. Of most importance to the people of Newfoundland are the health services provided by the Provincial Government. Of these, in Canada, two are peculiar to Newfoundland - the Cottage Hospital Service and the Children's Health Service.

HEALTH SERVICES ADMINISTERED AND FINANCED BY THE PROVINCIAL GOVERNMENT

The Cottage Hospital Service

24. At present, there are eighteen Cottage Hospitals in Newfoundland situated in coastal villages having in total about five hundred hospital beds. These are mostly wooden structures, some more than twenty years old, comprising from twenty to twenty-five beds and an out-patient clinic. One or two resident physicians run the clinic, the hospital, and make calls in the district.

25. The districts vary in size, population and accessibility. Parts of many districts are extremely isolated, especially during the winter. The population served by the Cottage Hospital Service numbers approximately 300,000 and currently the number of doctors employed is 38. (Twenty-two additional doctors,

[illegible] had also implemented a number of public health services which are now the function of [illegible]

which are now provided through the Federal Government were previously the function of the Commission of Government; others, introduced subsequent to Confederation, are of more recent origin.

23. Of most importance to the people of Newfoundland are the health services provided by the Provincial Government. Of these, in Canada, two are peculiar to Newfoundland - the Cottage Hospital Service and the [illegible]

HEALTH SERVICES ADMINISTERED OR FINANCED BY THE PROVINCE

The Cottage Hospital Service

24. At present, there are eighteen Cottage Hospitals in Newfoundland situated in coastal villages having in total about fifty bundred hospital beds. These are mostly wooden structures, some more than twenty years old, comprising from twenty to twenty-five beds and an out-patient clinic. One or two resident physicians run the clinic, the hospital, and make calls in the district.

25. The districts vary in size, population and accessibility. Parts of many districts are extremely isolated, especially during the winter. The population served by the Cottage Hospital Service

who are full-time Medical Health Officers, also provide services for these persons in areas where hospitals do not exist).

26 The method of remunerating these doctors has varied widely. Earlier, in addition to their stipend, they were allowed some private practice privileges, and could, for example, charge additional fees for obstetrics. Recently, private practice has been seriously curtailed by the Government. We believe that this has been a mistake, and that it must eventually be reflected in the quality of patient care because of the more limited opportunities now available. The more conscientious physician must eventually be affected, and the logical development is a much higher rate of referral to St. John's of cases which are more demanding in time and responsibility. Remuneration varies from nine thousand five hundred to eighteen thousand dollars yearly, and the trend is to establish these doctors as full time Provincial Civil Servants, thus eliminating the contractual relationship which has existed in the past.

27. This change in status has resulted in the requirement by Government that all Cottage Hospital doctors sign and agree to an Oath of Secrecy. While we recognize that this might apply to many employees of Government who are civil servants, we believe that its application to doctors who are treating patients is a dangerous precedent. Doctors could be prevented from accepting a position of leadership in their local communities in the correction of public health problems

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27 [illegible] doctors sign and agree to an oath of secrecy. While we recognize that this might apply to many employees of Government who are civil servants, we believe that its application to doctors who are treating patients is a dangerous precedent. Doctors could be prevented from accepting a position of leadership in their local communities in the correction of public health problems

and, in the extreme, could be prevented from making contributions to scientific journals.

28. The Government charges a nominal annual subscription fee of approximately $10.00 per family in the Cottage Hospital districts. There is no waiting period and little attention is given to continuity of yearly payments. These are often paid only after it becomes obvious that major medical services will be required. The total subscription collected makes only a token contribution to the cost of the Cottage Hospital Service. Most of the income now comes from general revenue and the Federal Hospitalization programmes. The services provided are as follows:

1. General Medical Service
2. X-Ray and Laboratory Service
3. Drugs and certain prosthetic appliances
4. Urgent and certain elective surgical procedures.
5. Obstetrics, consultations and referral services.

29. It is difficult to obtain and maintain trained personnel in the Cottage Hospitals, and the standard of care is apt to be low in many respects, particularly with regard to X-ray, laboratory service and surgical care. For all practical purposes, consultation and referral presumes transportation of the patient to St. John's or Corner Brook where specialists' services are available. This transportation is often financed by the Government which also pays a $5.00 consultation fee to the specialist involved.

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5. Obstetrics, consultations and referral

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referral overcome transportation of the patient to St. John's or Corner Brook where specialist services are available. This transportation is often done and by the Government which also pays a $5.00 consultation fee to the specialist involved

30. In 1938 the Government also established a scale of fees for specialist services provided to Cottage Hospital patients. This scale, which is still in existence, has never been essentially revised and averages about one-third of the 1956 minimum scale of fees of the Newfoundland Medical Association. Thus, the medical profession in large measure subsidizes the cost to government of providing the Cottage Hospital Service.

31. There is at the present time one specialist in internal medicine who makes periodic visits to the Cottage Hospital areas and received a Government stipend for this service. For all practical purposes dental services are non-existent in these areas.

Medical Health Officers

32. Another service, also operated by the Provincial Government, complements or supplements the Cottage Hospital Service in the more remote and inaccessible areas. There are approximately twenty-two doctors who work alone in sparsely populated sections of the Province. They have no hospitals. The facilities usually supplied include an office and a small motor launch with drugs and equipment provided by the Government. A larger vessel equipped as a floating clinic also functions on the South Coast. There is considerable yearly turnover among this group of physicians. The majority of the posts at present are filled by foreign doctors recruited by the Department of Health. They perform both public health

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and treatment services within their areas and they receive an average salary of $1,500 per annum.

The Children's Health Service

33. Inaugurated in 1957 and expanded in 1958, this service provides medical care in hospital to children under sixteen, and comprises five stages, existing or projected:

1. Hospitalization
2. Out-patient diagnostic services
3. Medical care in hospital
4. Dental and optical care
5. Offices and domiciliary visits

34. The first three states are now in operation, the benefits of the first two being identical with those available to the whole population under Federal-Provincial Hospital Insurance.

35. The plan is administered by the Department of Health. All in-patient medical and surgical services are covered. Accounts for treatment are rendered by individual doctors to the Department, and monthly settlements are made.

36. Payment is on a fee-for-service basis based on the 1956 Newfoundland Medical Association of Fees as follows:

MEDICAL	First 30 days	- 80% of Schedule
	Second 30 days	- 40% of Schedule
	For premature babies	- 50% of the two preceding rates.

No payment to be made after first 60 days of hospitalization.

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MEDICAL	First 30 days	- 50% of Schedule
	Second 30 days	- 40% of Schedule
	For premature babies	- 50% of the two

No payment to be made after first 30 days of hospitalization

In long term or complicated cases, payment may be allowed for procedures or operations.

SURGICAL 80% of Schedule

37. A limitation on earnings has been imposed for paediatricians. When the payments to a particular paediatrician, calculated from the beginning of a contract year, reach $14,000, he thereafter receives for the remainder of that year 25% of the agreed fees.

38. The above schedule does not apply to the Cottage Hospital Service areas where payment for children's treatment is included in the doctor's general remuneration contract. This exception also applies to the Isolation Hospital, the Tuberculosis Sanatoria and the Mental Hospital, where treatment is provided by doctors who are full-time employees of Government.

Cost of Physicians' Services in the Children's Health Scheme

	1958 (from 1st.Feb.)	1959
Surgeons	$91,795.50	$86,477.58
Paediatricians	$82,479.00	87,827.70
Anaesthetists	21,702.80	23,767.00
Otolaryngologists	52,292.40	34,879.60
Orthopaedists	29,749.00	39,310.20
Other Specialists	18,077.70	19,901.80
General Practitioners	54,145.20	47,513.05
	$320.348.80	$339,676.93

39. Although final figures for 1960 are not yet available, the total sum expended was approximately

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[illegible]

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Otolaryngologists	52,202.40	34,076.00
Orthopaedists	29,749.00	59,310.20
Other Specialists	16,017.70	19,990.30
General Practitioners	4,[illegible].70	47,919.05
	$[illegible].30	$[illegible].95

$355,000 for all in-hospital medical services excluding pathology, radiology and those services which were provided by doctors who are remunerated on a salary basis. The cost of services rendered by Cottage Hospital doctors is not included in this total.

Child Population

40. The total population under 16 in Newfoundland, according to the 1959 intercensal estimate, was 194,900. A breakdown of this figure by age groups is as follows:

Under 1 year	- 14,000
1 year	- 13,500
2 - 5	-56,700
6 - 15	-110,700

Number of Child Hospital Beds

41. The average number of beds occupied by children in 1959 was 450.

Children Hospitalized in 1959 and corresponding patient-days by age group

	Patient	Patient Days
Under 1 year	3,690	55,278
1 year	1,150	18,353
2 - 5	2,527	37,067
6 - 16	4,955	66,146
	12,322	176,844

42. A Medical Services Committee exists to consider day-to-day problems which arise from the operation of the Plan, particularly with regard to the assessment of accounts which cannot be easily determined from the

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6 - 16	4,355	66.15%
	12,322	176.84%

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Schedule. This committee which meets frequently comprises three members of the Newfoundland Medical Association and representation from the Dept. of Health.

43. Envisaged at the inception of the Plan was a Medical Advisory Committee which would study the working of the Plan and, from time to time, suggest improvements. The executive of the Newfoundland Medical Association has itself assumed the responsibility for this committee activity.

Workmen's Compensation Board

44. Although it confines itself to the realm of industrial medicine including trauma and disease, the Workmen's Compensation system in Newfoundland, as in other Canadian Provinces, is a compact, efficient prepaid medical care plan completely comprehensive within its sphere and operated on the fee-for-service principle. The Board has its headquarters in St. John's and, at present, there are two part-time administrative Medical Officers.

45. Treatment of medical and surgical conditions for Workmen's Compensation cases is provided by private doctors on a fee-for-service basis which is, at present, 90% of the Newfoundland Medical Association Schedule of Fees. During the last year under review about 10,000 accidents were reported, and of these 3,331 were sufficiently severe to cause temporary total disability for more than three days.

46. One important deficiency in the operation of this medical service results from an acute shortage of rehabilitative facilities in the Province.

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46. One important deficiency in the operation of this medical service results from an acute shortage of rehabilitative facilities in the Province.

Whil the general practitioners and the specialists, particularly the orthopaedic surgeons, endeavour to rehabilitate their patients, they are severely handicapped by the almost complete lack of a consultant service and ancillary facilities and personnel.

47. In Newfoundland there are no physiatrists and relatively few physiotherapists. The one rehabilitative service available is the Sunshine Camp for Children. We do not believe that the Workmen's Compensation Board has been sufficiently active in the development of rehabilitative services for adults - particularly those adults whose medical condtions result from industrial accidents.

Mental Health Services

48. In Newfoundland, as in other parts of Canada, the treatment of mental illness has long been accpeted as the responsibility of the Province through its Department of Health. In the past, the absence of effective definitive treatment has resulted in the development of custodial care institutions providing deplorable conditions for these unfortunate persons.

49. Recently, developments in therapy have allowed more patients to be treated without admission to institutions, and, as a result, two private psychiastrists are now practising in St. John's. However, much more needs to be done to provide for the mentally ill the benefits of modern medical advances. To this end, certain specific recommendations are listed sub-sequently in this presentation.

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48. In Newfoundland, as in other parts of Canada, the treatment of mental illness has long been accepted as the responsibility of the Province through its Department of Health. In the past, the success of development of ambulatory care institutions provides favorable conditions for these unfortunate persons.

49. Recently, developments in psychiatry have allowed more patients to be treated without admission to institutions, and, as a result, two private psychiatrists are now practicing in St. John's. However, much more needs to be done to provide for the mentally ill the benefits of modern medical advances. To this end certain specific recommendations are listed sub-sequently in this presentation.

Tuberculosis Services

50. Tuberculosis, as a disease entity, has been far more prevalent in Newfoundland than in other parts of C nada. We have mentioned previously the very early work in this field by Dr. Herbert Rendell and his co-workers. Each subsequent generation of physicians found this problem most acute and there has been close co-operation between the profession, the Government and the Newfoundland Tuberculosis Association in their efforts to control the disease.

51. As new techniques for prevention and case finding became available, broad programs were instituted by the Department of Health. The B.C.G vaccination program has had very satisfactory results. Case finding through free chest x-rays is carried out by all hospitals and by the survey units of both the Department of Health and the Newfoundland Tuberculosis Association.

52. New drubs and new surgical techniques have reduced the mortality rate and the period required for treatment. Now, beds are becoming available in our sanatoria for use in the treatment of other diseases.

53. It would be wrong, however, to conclude that we can relax our vigilance in tuberculosis control. The sputum-positive case is a great danger to a community which consists of persons previously uninfected. This has brought us to the paradoxical situation in which, despite the decline in tuberculosis cases, it is necessary to strengthen, not weaken, the control exercised over actual and potential sources of infection. For Newfoundland this means that the closer we approach

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the goal of control and eventual eradication of tuberculosis, the more each succeeding step in case finding will cost in personnel and money. The smaller the 'pool' of active cases of infection becomes, the greater the effort required to maintain control and reduce the disease further.

HEALTH SERVICES ADMINISTERED AND FINANCED BY THE FEDERAL GOVERNMENT

The Department of Veterans' Affairs

54. In Newfoundland, the Department of Veterans' Affairs maintains one full time salaried Medical Officer and, as well, has a panel of consultants, all specialists, who receive a stipend which is calculated on a sessional basis. General medical care is provided by private practitioners and eligible veterans may have the doctor of their choice whenever this is possible. Payment to these doctors is on a fee-for-service basis calculated at 90% of the current Newfoundland Medical Association Schedule of Fees.

55. Approximately 2,950 veterans are eligible for medical services. Of these, thirteen hundred are eligible for unlimited medical care, and a further 1,650 are eligible for limited care, i.e., their treatment is limited to their pensionable disability.

56. Veterans without pensionable disability but whose income is small enough to satisfy a means test may also receive medical care including hospitalization through the Department of Veterans Affairs. The D.V.A. ward in the St. John's General Hospital has 30 beds. The new Pavilion in the process of construction will have

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54. In Newfoundland, the Department of Veterans' Affairs maintains one full time salaried medical officer and, as well, has a panel of consultants, all specialists, who receive a stipend which is calculated on a seasonal basis. General medical care is provided by private practitioners and eligible veterans may have the doctor of their choice whenever this is possible. Payment to these doctors is on a fee-for-service basis calculated at 90% of the current Newfoundland Medical Association Schedule of Fees.

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80 beds and improved facilities for the treatment of veterans.

Immigration and Sick Mariners' Service

57. As Newfoundland is a coastal island arrangements must be provided for the medical screening of immigrants and the treatment of sailors of foreign ships who become ill.

58. The Federal Department of Health and Welfare provides one full-time physician in Newfoundland for its immigration service and has made arrangements with one physician in private practice to provide medical care for sick mariners. While we agree that correlation of services provided to sick mariners requires the appointment of a single physician for purposes of supervision, we believe that it should be possible to provide a wider choice of doctors for the treatment of these patients.

Federal Health Grants

59. The Newfoundland Department of Health has utilized a higher proportion of monies available under the health grant program than any other Province in Canada. We believe that this has been a very effective method of assisting this Province in up-grading both the quality and the quantity of services available to the public.

60. During recent years, the monies have been used to expand public health and rehabilitation services, to train personnel - nurses, laboratory technologists and other ancillary personnel, to provide specialized equipment and to augment transportation for the movement of

[illegible]

[illegible]

[illegible]

of the sick.

61. We recommend that this system of Federal Health Grants be expanded and the allocated monies augmented to further assist in raising the standards of health services.

THE HOSPITAL AS AN ELEMENT OF MODERN MEDICAL CARE

62. In the introduction to this submission and in our description of medical practice in Newfoundland we have commented, in a general way, on the development of the hospital service. The first hospitals in Newfoundland were military institutions. St. John's General Hospital was originally a military hospital, which became surplus to their requirements. The initial impetus to hospital construction was to provide additional institutions for the separate treatment of the mentally ill and those afflicted with tuberculosis. Subsequent development was in the periphery, endeavouring to provide facilities for emergency treatment in the outlying areas. The Grenfell Mission hospitals were the first institutions built in trying to fulfill this need. It is of more than passing interest that these institutions were financed from private funds as a philanthropy.

63 Other private organizations were instrumental in increasing the number of hospital beds available throughout Newfoundland thus making available to the public the advanced forms of treatment which could only be provided in hospitals. In 1920 the Newfoundland Outport and Industrial Association (Nonia) was

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63. Other private organizations were instrumental in increasing the number of hospital beds available throughout Newfoundland thus making available to the public the advanced forms of treatment which could only be provided in hospitals. In 1920 the Newfoundland Outport and Industrial Association (Nonia) was

1 started and provided specially trained District Nurses
2 for the outports. In 1922 the Roman Catholic Church
3 opened St. Clare's Mercy Hospital which has since
4 grown to a capacity of 132 beds; in 1923 the Salvation
5 Army Grace Hospital was erected, and this has since
6 expanded to 187 beds. Paper manufacturing and mining
7 companies supplied hospitals for their employees and
8 families in Corner Brook, Grand Falls and Buchans.
9 64. Public subscription assisted many of these
10 organizations in their need for capital funds. More
11 recently a combination of employer contributions and
12 public subscriptions built the Western Memorial Hospital
13 in Corner Brook, and last year public subscriptions
14 supplied a considerable proportion of the cost of the
15 projected 200 bed hospital in central Newfoundland.
16 65. The direct financial interest of Governments
17 in the building of hospital beds through Federal and
18 Provincial grants is a phenomenon well known in all
19 Provinces of Canada. In Newfoundland this interest has
20 been more direct and with this direct interest there
21 has proceeded a substantial degree of Government control.
22 Eighteen Cottage Hospitals in Newfoundland comprising
23 approximately 500 beds have been built by the Government
24 and are maintained today by Government resources through
25 the Cottage Hospital system. As well, the Government
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30 66. Thus the history of hospital construction in

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65. The direct financial interest of Governments in the building of hospital beds through Federal and Provincial grants is a phenomenon well known in all Provinces of Canada. In Newfoundland this interest has been more direct and with this direct interest there has proceeded a substantial degree of Government control. Eighteen Cottage Hospitals in Newfoundland comprising approximately 500 beds have been built by the Government and are maintained today by Government resources through the Cottage Hospital system. As well, the Government has contributed through the years a substantial proportion of the cost of additional beds and additional services and facilities in the St. John's General Hospital.

Thus the history of hospital construction in

the Province has consisted of a constant struggle to provide facilities for emergency treatment near at hand to a widely scattered group of communities. It has not been possible to provide even the most rudimentary of modern facilities in many of these far flung small hospitals. To compensate for these inadequate facilities, an excellent air ambulance service is available to transfer patients requiring special services to St. John's and Corner Brook. In St. John's, and to a lesser degree in Corner Brook, evolution within the private practice of medicine has provided a trained group of specialist physicians who use the modern facilities available through their hospitals to provide the most advanced scientific techniques for their patients.

THE HOSPITAL INSURANCE AND DIAGNOSTIC SERVICES ACT

67. More than half of the population of Newfoundland had a partial coverage for hospitalization through the Cottage Hospital Service long before the introduction of the Federal Hospital Insurance and Diagnostic Services Act. The passing of this Act, however, enabled the Government of the Province of Newfoundland to extend coverage to all residents of the Province. The financial cost-sharing arrangements which were negotiated were very favorable to this Province and it is our understanding that the program now in effect is not much more burdensome upon the Provincial Treasury than the expenditures which they had previously assumed.

68. Part of the reason for this curious effect is, of course, a chronic shortage of hospital beds. The

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extension of coverage to all residents of the Province has certainly created an increased demand for hospital admissions and hospital facilities. Many cases, particularly those requiring elective surgery and non-emergency investigation, cannot be admitted to hospital because of the shortage of beds. This militates against maintenance of quality of care.

69. It is our opinion that the introduction of Hospital Insurance has contributed to an improvement in the quality of hospital services provided to our patients. The more ready availability of ancillary hospital services has allowed more complete investigation leading to improved quality of care. In addition, some persons, who prior to the introduction of this program were loath to accept hospital treatment due to the cost, now are able to obtain the full benefit of these services.

70. The introduction of hospital insurance in this Province has certainly reduced the total health bill to the patient. Most patients in the private practice areas now find themselves more able to pay or prepay the cost of medical services. There are, of course, some patients whose financial circumstances are such that the cost of medical services is still beyond their ability to pay. The medical profession in Newfoundland recognizes the difficulties which these patients face and doctors throughout the Province have long demonstrated their willingness to provide their services without fee from patient, or government, for these persons in needy circumstances.

has certainly created an increased demand for hospital admissions and hospital facilities. Many cases, particularly those requiring elective surgery and non-emergency investigation, cannot be admitted to hospital because of the shortage of beds. This militates against maintenance of quality of care.

69. It is our opinion that the introduction of Hospital Insurance has contributed to an improvement in the quality of hospital services provided to our patients. The more ready availability of ancillary hospital services has allowed more complete investigation leading to improved quality of care. In addition, some persons, who prior to the introduction of this program were loath to accept hospital treatment due to the cost, now are able to obtain the full benefit of these services.

70. The introduction of hospital insurance in this province has certainly reduced the total health bill to the patient. Most patients in the private practice areas now find themselves as more able to pay or prepay the cost of medical services. There are, of course, some patients whose financial circumstances are such that the cost of medical services is still beyond their ability to pay. The medical profession in Newfoundland recognizes the difficulties which these patients face and doctors throughout the Province have long demonstrated their willingness to provide their services without fee from patient, or government, to those persons in needy circumstances.

METHODS OF IMPROVING HEALTH SERVICES

Extension of Private Practice

71. Our review of medical services in Newfoundland has indicated that there are outside St. John's a few small areas of economic self-sufficiency. In these areas the private practice of medicine has provided as high a quality of service as is consistent with the exigencies of geography. The remainder of the Province comprises the Cottage Hospital Service areas and here we feel the quality of service has varied very greatly.

72. There are two measures by which we can determine the relative quality of service. One is the stability of the doctor population, and the other is the physician population ratio.

73. Disregarding those doctors who have died or retired, the following Table indicates the number of doctors in 1950 and again in 1955 who have remained in the Province up to the year 1961, or who have left. Those doctors who originally enrolled in the Cottage Hospital Service and subsequently entered private practice in Newfoundland are still credited to the Cottage Hospital area statistics:

STABILITY OF THE DOCTOR POPULATION

	Private Area		CHS Area	
	Remained	Emigrated	Remained	Emigrated
1955 - 61	72	23 -(24%)	37	25 -(40%)
50 - 61	54	12 -(18%)	22	16 -(42%)

1925 -30	45	8 -(15%)	34	10-(23%)

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73. Disregarding those doctors who have died or retired, the following Table indicates the number of doctors in 1950 and again in 1955 who have remained in the Province up to the year 1951, or who have left. Those doctors who originally enrolled in the Cottage Hospital Service and subsequently entered private practice in Newfoundland are still credited to the Cottage Hospital area statistics.

Period	Private Area		Cott. Area	
1950 - 51	54	12 -(18%)	27	
1925 -30	45	8 -(18%)	34	10-(23%

74. It can readily be seen that the degree of loss by migration from the private practice area is significantly less than from the Cottage Hospital Service area. For both time periods the proportionate loss in the Cottage Hospital areas is approximately twice that in the private practice area. It is interesting to note that a study of the period 1925 to 1930, prior to the introduction of the Cottage Hospital Service, does not indiciate such a marked difference.

75. It is our opinion that physicians practising privately under non-Government auspicies tend to root themselves more firmly in the local community and render services to their patients on a longer term basis. It is further our opinion that this circumstances provides a higher quality of service for their patients.

76. Newfoundland's population is estimated at 462,000. Of this total approximately 125,000 reside in the private practice areas, and the remaining 337,000 live in the Cottage Hospital areas. The private areas are served by 139 physicians in private practice; the Cottage Hospital areas are served by 60 doctors, and the remaining doctors are employed by government in other fields.

77. Thus the physician population ratio in the private practice areas is 1:899, in comparison with a ratio of 1:5,600 in the Cottage Hospital areas. We recognize that all of this discrepancy cannot be attributed to the difference in method, (as some private doctors provide some services for Cottage Hospital patients, and private practice in the C.H.S.

74. It can readily be seen that the degree of loss by migration from the private practice area is significantly less than from the Cottage Hospital Service area. For both time periods the proportionate loss in the Cottage Hospital areas is approximately twice that in the private practice area. It is interesting to note that a study of the period 1925 to 1930, prior to the introduction of the Cottage Hospital Service, does not indicate such a marked difference.

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areas would never improve the ratio to that which now applies in the more economically stable and geographically compact private areas), but it is our contention that given similar circumstances private practice will attract more doctors and thus provide a better quality of care.

78. The growth in the number of doctors in Newfoundland from 154 in 1950 to 275 in 1961 is largely derived from the increase in the number of doctors in private practice areas. The most significant increase is noted in the number of specialists, largely in private practice. While it is true that some of this number were subsidized by government and many provide services for C.H.S. patients as well as private patients, nevertheless the growth would have been much less if these new doctors had not been attracted by the conditions of private practice. The Cottage Hospital Service does not of itself attract specialists, but must depend for its referred work upon those who were basically attracted to the Province by private practice conditions.

79. This critical analysis of certain aspects of the Cottage Hospital Service does not indicate thatthe medical profession in Newfoundland considers that the service does not fulfill a useful function. We believe that the present, or a similar service will be necessary for many years in some of the outlying areas of the Province. We do, however, believe that the policies of Governments should be such as to develop self-sufficiency in these areas as soon as possible, and that

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the population of these areas should be encouraged to develop arrangements for the private practice of medicine in the communities.

80. We are concerned about the demonstrated tendency of the Government of Newfoundland to extend the Cottage Hospital Service by enrolling new areas. We believe that this practice is detrimental to the development of an increasing quality of medical services for these persons. The medical profession in Newfoundland is ready to assist in any way possible the development of a higher standard of service by the extension of private practice in this Province.

MEDICAL SERVICES INSURANCE

81. We believe this can be accomplished by the gradual extension of a prepayment mechanism suited to Newfoundland's geographic and economic problems. We have stated previously that only one-eighth of the population of the Province is insured in whole or in part for the cost of necessary medical services. We believe that a more widespread application of the prepayment principle would be beneficial to our patients and would allow the enlargement of the areas now served by private practitioners.

82. We are aware of the problems inherent in the development of a program of Medical Service Insurance to meet the specific needs of our Province. In Newfoundland continuity of employment is the exception rather than the rule. The per capita income of our residents is low. The financial capacity of our Provincial Treasury is limited. Education standards

to develop arrangements for the private practice of medicine in the communities.

80. We are concerned about the demonstrated tendency of the Government of Newfoundland to extend the Cottage Hospital Service by annexing new areas. We believe that this practice is detrimental to the development of an increasing quality of medical services for these persons. The medical profession in Newfoundland is ready to assist in any way towards the development of a higher standard of service by the extension of private practice in this Province.

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are low and many of our fellow citizens do not understand or appreciate the need for such insurance.

83. It is for these reasons that we propose an arrangement based on regional development which will allow gradual implementation. We suggest that the Province be divided into regions approximating the existing Cottage Hospital Service areas. Existing private practice areas would be included so that the ultimate extension would provide an insurance arrangement for all Newfoundland.

84. The adoption of a voluntary prepaid system of underwriting the cost of medical services is advocated. This would alter each existing Cottage Hospital Service area to a private practice area and would encourage additional doctors to practicke in these communities.

85. In each area a Board of Directors would be set up, composed of the leading local citizens. In consultation with Government officials, the Board would determine that level of premium for medical services insurance which would be reasonable to expect to collect on the basis of the local economy. The remainder of the cost of underwriting the insurance program on a private practice fee-for-insurance basis would be borne by the Government. Because the amount of subsidy would in total be substantial, we believe that it would be necessary for the Federal Government to share these costs with the Provincial Government.

86. The local Board of Directors would offer this coverage on a voluntary basis to residents of their area. Persons stating their inability to pay would, if

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86. The local Board of Directors would offer this coverage on a voluntary basis to residents of their [illegible]

approved on a needs test basis, have their premiums paid by Government. The Board would administer the program and pay the doctors' accounts.

87. It is our firm belief that the introduction of such an insurance arrangement would attract sufficient doctors to these areas to improve substantially the quality of medical services. We would envisage as benefits all physicians' services provided locally, plus the services of specialist physicians and others in the larger medical centres of the Province. Fees from the plan would provide complete payment for services excepting that, in the initial stages at least, a small deterrent fee should be used to minimize frivolous demands on the doctors' time.

88. The successful introduction of this insurance arrangement would require the sympathetic understanding and co-operation of Government. The first areas would require careful selection. Public education would be necessary. Some time would necessarily elapse before the increased requirement for doctors could be met. We believe, however, that the result would be worth the effort and that improved health care would be provided. The Newfoundland Medical Association would, of course, be most anxious to assist in any way possible in the development of the program.

MENTAL HEALTH SERVICES

89. During the past few years there have been tremendous developments in the treatment of mental illness; these relate both to new concepts of treatment and the new forms of drug therapy. As a result, the

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large custodial institution is, in many ways, outdated; and the trend of modern therapy is to establish small hospitals for the treatment of the mentally ill adjacent to General Hospitals and small psychiatric units within the larger general hospitals.

90. We believe mental illness requires the same consideration, care and attention as provided for other types of illnesses, i.e., diagnostic facilities, treatment facilities, out-patient clinics, private practice facilities, hospital facilities, proper case follow-up and rehabilitation services.

91. These basic needs can be facilitated in the future by bringing the treatment of the mentally ill into a comprehensive general medical care program. This would provide continuity of care in a general hospital atmosphere reasonably close to the patient's home. It is our view that this would contribute substantially to the rehabilitation of a much higher proportion of patients suffering from mental illness.

THE PRESENT AND FUTURE REQUIREMENTS OF PERSONNEL TO PROVIDE HEALTH SERVICES.

92. Newfoundland has two hundred and seventy-five doctors to provide medical services to a total population of 462,000 persons. This provides a doctor population ratio of one physician for each 1,680 persons - poor by comparison with the national average of one physician for each 879 persons. Our physician shortage is even more acute than this comparison reveals, because our sparse population and difficult geography would require a physician population in excess of the national average

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THE PRESENT AND FUTURE ADJUSTMENT OF PROGRAMS TO [illegible]

92. Newfoundland has two hundred and seventy-five doctors to provide medical services to a total population of 465,000 persons. This provides a doctor population ratio of one physician for each 1,690 persons - poor by comparison with the national average of one physician for each 875 persons. Our physician shortage is even more acute than this comparison reveals, because our [illegible] population in excess of the national average

to achieve the same quality of service.

93. It is our belief that the creaton of conditions conducive to a good standard of private practice throughout Newfoundland would itself provide the impetus to recruit the number of doctors which we need in this Province. Special assistance may be required from Governmental sources to attract specialists to strategic areas throughout the Province. However, in most instances, the provision of such assistance should be a temporary measure as time and the education of the population would gradually provide sufficient private practice for these physicians to obviate the continued need of subsidy.

94. An improved health service for Newfoundland of the type which we have described would also require an additional supply of nurses, radiological, laboratory, and other technicians, to man the improved facilities which will be required. Studies should be carried out to determine whether it would be possible for us to train a sufficient number of young Newfoundlanders in the Province to meet the future demand. This would provide increased opportunity for the youth of the Province and might assist in retarding our export of the best young minds in Newfoundland to other sections of the country. Specifically, we would recommend that nursing schools be established in Corner Brook and subsequently in Central Newfoundland when the proposed hospital is completed. Training of nurses' aides should be an urgent consideration. It is as well possible that the training of the technicians required

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[illegible]

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could be undertaken at the Vocational Schools now being established.

METHODS OF PROVIDING ADEQUATE PERSONNEL WITH THE BEST POSSIBLE TRAINING AND QUALIFICATIONS FOR SUCH SERVICES.

95. We have mentioned the possibility of training schools in the Province for certain technical personnel which will be required in the future. Consideration should also be given to the possibility of establishing a medical school in Newfoundland in connection with out Provincial University, or in affiliation with Dalhousie University. If this is not feasible, consideration should be given to the provision of scholarships and bursaries so that more Newfoundlanders would be able to meet the heavy financial requirements of a course in medicine.

96. We do not believe that academic requirements should be lowered, or that we should envisage the utilization of physicians with inferior training to meet the requirements which we foresee. The requirements for registration with our Medical Board must be the minimum requirements which are acceptable if we are to continue to protect the public from the quack and the charlatan.

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of British and Irish physicians who have emigrated to Newfoundland. It is our opinion that we would have retained in this Province a larger proportion of these immigrant physicians if conditions of private practice prevailed throughout Newfoundland.

98. The establishment of a medical school in Newfoundland would greatly assist in the continuing education of the profession in Newfoundland. The willingness of the general practitioners in the Province to undertake post-graduate education is evident from the high percentage who are members of the College of General Practice of Canada - the highest proportion of any Province. Unfortunately, this willingness is not matched by the facilities available, although considerable improvement has been noted in recent years through the efforts of local doctors and the co-operation of the medical school at Dalhousie University.

THE PRESENT PHYSICAL FACILITIES AND THE FUTURE REQUIREMENTS FOR THE PROVISION OF ADEQUATE HEALTH SERVICES.

99. Newfoundland has an acute shortage of modern hospital beds and modern hospital technical facilities. This is true in St. John's, and it is also true throughout the length and breadth of this Island.

100. St. John's has approximately 767 general hospital beds; Corner Brook has 107; and there are approximately 1,000 additional beds scattered throughout the Province. This provides a Provincial average of just under 4 beds per thousand persons, compared with the national average of almost 6 beds per thousand

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THE PRESENT PHYSICAL FACILITIES AND THE WHOLE REQUIREMENTS FOR THE PROVISION OF ADEQUATE HEALTH SERVICES.

99. Newfoundland has an acute shortage of modern hospital beds and modern hospital technical facilities. This is true in St. John's, and it is also true throughout the length and breadth of this Island.

100. St. John's has approximately 76% general hospital beds; Corner Brook has 10%; and there are approximately 1,000 additional beds scattered throughout the Province. This provides a Provincial average of just under 4 beds per thousand persons, compared with the national average of almost 6 beds per thousand

persons. Even this comparison does not present our shortages in their true light. Newfoundland's population is increasing by 10,000 - 12,000 persons yearly, and this natural increase must be taken into consideration in projecting future needs. Many of the beds in outlying areas are old and the hospitals are poorly equipped. Replacement is as acute a need as new construction.

101. We urgently require approximately 1,000 additional general hospital beds, plus an additional 60 beds per year to account for expected population growth.

102. This would improve our ratio to 5.75 beds per thousand persons. Of this number it is proposed that 350 beds will be built in Central Newfoundland within the next few years. In Corner Brook, it is expected that 150 beds, surplus to the requirements of the Sanatorium, will be made available for general hospital purposes.

103. The remaining 500 beds will largely be required in the St. John's area. Of this number, a proportion should be added to the private hospitals and the remainder allocated for the expansion of the general hospital. If we accept the proposal of the ultimate development of a medical school in St. John's , much care and attention should be given to the development of hospital beds in this area, as we should contemplate the eventual need for a University Hospital, representative of all disciplines, to meet the needs of the medical school.

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BEDS FOR THE MENTALLY ILL

104. Newfoundland has one mental hospital, an annex and a psychiatric unit, all in St. John's. Over 900 patients are being cared for but at least 250 of these are housed in accomodation which is below minimum standards. Using as a basis of need the modest requirement of 3.5 beds per thousand persons, we require an additional 1,000 beds for our present population.

105. It is perhaps, fortuitous that his requirement has not been met prior to the development of the present methods of treatment. We are advised that the 1,000 additional bed requirement should be implemented by building smaller hospitals of approximately 200 to 250 beds in St. John's, Corner Brook and Central Newfoundland, plus psychiatric units, up to 40 beds in size, in each of the larger general hospitals.

106. We believe that this undertaking is urgently required, and we recommend that Federal funds be made available for such construction in order to implement as quickly as possible the new approach to the treatment of the mentally ill.

CONVALESCENT BEDS

107. Newfoundland does not have a single convalescent bed. Minimum standards would require approximately one bed per thousand persons or 500 convalescent beds for this Province. We believe that these beds can be built at lower cost than general hospital beds and that they can perform a useful function,

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primarily for the post-operative patient.

108. We have recommended that one floor of the Pepperrell Hospital be used to accomodate 125 convalescent patients. Additional beds should be provided adjacent to, or as part of, other general hospitals throughout the Province.

BEDS FOR THE CHRONICALLY ILL

109. The provision of chronic beds is perhaps a social problem rather than a medical problem. Certainly, if chronic beds were available, beds in our general hospitals could be released for more active use. It is, however, almost impossible to predict the number of such beds which should be built. Estimates from other provinces vary from 1 to 2.5 beds per thousand population. Even on the basis of the minimum standard, we would require 500 beds in this category.

REHABILITATION

110. We have mentioned the lack of rehabilitative facilities relative to the needs of injured adults. The only rehabilitation service in existence is the Sunshine Camp for children. We have recommended that this service be augmented to 50 beds and be moved to the ground floor of the Pepperrell Hospital.

111. New beds and facilities need to be established in all larger hospitals in Newfoundland. The provision of such facilities would encourage the establishment of physiatrists in the Province to provide the necessary consultant service.

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112. Many of our hospitals urgently require special facilities which, with the development in the science of medicine, have become an integral hospital requirement. We recognize the need for a better distribution of the specialists available throughout the Province. It is, however, impossible to locate a specialist in a community without having available to him the special facilities which he requires for the practice of his speciality. We hope that the building of the proposed hospital in Central Newfoundland will alleviate these conditions to some degree. However, a further development of this Base Hospital system with the necessary integrated facilities is necessary if we are anticipating the provision of an improved standard of medical care for the citizens of this Province.

THE METHODS OF FINANCING ANY NEW OR EXTENDED PROGRAM WHICH MAY BE RECOMMENDED

113. We, the Medical Profession of Newfoundland, are acutely aware of the problem presented in financing the increased standard of health care which we consider necessary for our fellow citizens.

MEDICAL SERVICES INSURANCE

114. We have recommended that a system of voluntary prepayment of the cost of medical services be instituted. The regional nature of our proposal would allow the establishment of different premium levels. Some areas of our Province have very limited resources and relatively few persons who are gainfully employed. These areas should not be required to pay,

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by premium, as high a proportion of the costs of such a programme as other areas which are more economically self-sufficient.

115. We recommend that the program costs, beyond the ability of the local areas to subscribe, be shared by the Federal and Provincial Governments. The total amount of such subsidies is very difficult to predict. Initially the amount would be small. However, as additional doctors are drawn to these areas, by the conditions of private practice, costs will rise.

MENTAL HEALTH

116. In our statement of deficiencies we have noted that Newfoundland has an acute shortage of hospital beds for the mentally ill. One thousand additional beds are urgently need to maintain modest standards.

117. We do not believe that the resources of our Province are sufficient to provide these additional beds at this time. We are concerned that undue delay will prevent an early introduction of new methods of treating the mentally ill.

118. We, therefore, recommend that the Federal Government undertake to assume all, or almost all, costs of construction of new hospital beds for the mentally ill. For Newfoundland the total capital cost would be ten to twelve million dollars.

119. The erection of these beds would, of course, substantially increase the operating cost of the

by premium, as high a proportion of the costs of such a programme as other areas which are more economically [illegible]

115. We recommend that the program costs, beyond the ability of the local areas to subscribe, be shared by the Federal and Provincial Governments. The total amount of such subsidies is very difficult to predict. Initially the amount would be small. However, as additional doctors are drawn to these areas, by the conditions of private practice costs will rise.

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Provincial Mental Hospitals. The yearly increase would approximate 4.5 million dollars. We would recommend that the operating costs of mental hospitals be accepted by the Federal Government as shareable costs under the Hospital Insurance and Diagnostic Services Act.

OTHER HOSPITAL BEDS

120. We have outlined deficiencies of 1,000 general hospital beds, 500 convalescent beds and 500 beds for the chronically ill. Of this number 500 general hospital beds will be built the next few years and 125 convalescent beds will become available when the Pepperrel Hospital is converted. Some easement in the requirement for general hospital beds may be realized if the additional convalescent beds and the beds for the chronically ill were provided.

121. It is likely, however, that natural population increase and the consequent hosital bed requirements will off-set these factors. We, therefore, must find, in the relatively near future, $10,000,000 for the capital cost of additional general hospital beds and $8,750,000 for the construction of needed beds for the convalescent and the chronically ill.

122. While we believe that our Province can finance these obligations over the long term (with the assistance of present Federal Hospital grants), we consider that it is unlikely that funds can be made available, at this time, over and above the commitments for future hospital bed construction which have already

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been assumed. We would, therefore, suggest that study be given to the establishment of a Federal lending agency to assist in such construction, and that consideration be given to the acceptance by both Federal and Provincial Governments of depreciation of hospital buildings as a shareable cost under the Hospital Insurance and Diagnostic Services Act.

123. We realize that the proposals which we have suggested cut across traditional Federal-Provincial responsibilities. We believe, however, that the needs of our people for medical care are of prime importance. They are both residents of Newfoundland and citizens of Canada. We do not believe that the traditions of the past should take precedence over the needs of the future.

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COMMISSIONER BALTZAN: Mr. Chairman. In your brief, Dr. Baird, one of the references here is to the matter of doctors who join the Department of Health or public service and you mention a recent edict which classified them as civil servants and who must sign and agree to an oath of secrecy. Some of us here have never been in the civil service and we don't know what that stands for, and I don't think I can ask you to qualify that entirely, but let me ask you just this question in this connection: this matter of secrecy -- an oath of secrecy: how does this apply to confidential matters upon which patients rely upon doctors?

DR. BAIRD: Perhaps I can answer that in this way, and say that as the wording of the oath is read it has a very wide application.

THE CHAIRMAN: Have you got it?

DR. BAIRD: Yes, I think we have it here. Would you like us to read it?

THE CHAIRMAN: Yes.

DR. BAIRD: There are two sections: the oath of allegiance which is the usual oath of allegiance to Her Majesty Queen Elizabeth; however, this is called the oath of office: "I, (blank), do swear solemnly, sincerely and truly declare and affirm that I will faithfully, honestly and impartially to the best of my knowledge, skill and ability, perform my duties as a civil servant and that I will not directly or indirectly without due authority disclose to any person any information or other matter which may come to me in the performance of those duties or by reason of my employment as a civil servant. So help

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me God".

COMMISSIONER BALTZAN: You believe, then, that this is an impediment insofar as a physician-patient relationship on a confidential basis is concerned?

DR. BAIRD: Yes sir, we do.

COMMISSIONER BALTZAN: You would in obedience to this have to disclose certain things that would be unpalatable both to the patient and physician?

DR. BAIRD: Yes, and also because of the wide wording, the uncertainty of what you are allowed to discuss has also been raised on several occasions.

THE CHAIRMAN: What do you mean by that? I am trying to get the full implication of your suggestion. I may not have heard the document fully, but I didn't discern anything that required you to disclose anything; that it was a break in disclosure rather than a direction to disclose, isn't it?

DR. BAIRD: Yes, sir. It is preventing you from disclosing rather than the other way around.

THE CHAIRMAN: Well, what would you want to disclose that you would be prevented from disclosing?

DR. BAIRD: Well, things like health matters in the community.

THE CHAIRMAN: Will you amplify that?

DR. BAIRD: Supposing there is a dangerous situation with regard to the disposal of material from a hospital, we will say, that is endangering the citizens of the village or town, and perhaps this could not be discussed by the doctor before the town council, or something like that.

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THE CHAIRMAN: Without the permission of whom?

DR. BAIRD: Well, I gather it is at the discretion of the Minister of Health. I think this is where the doctors refer for permission.

COMMISSIONER VAN WART: Do I understand if one of these doctors went to a Medical Society meeting where certain diseases on the program were being discussed that that doctor could not take part in the discussion at that meeting?

THE CHAIRMAN: Without authority.

COMMISSIONER VAN WART: Without prior consultation on what he says with his Minister.

DR. BAIRD: I don't think I am in a position to answer what exactly is the actual interpretation, sir.

COMMISSIONER VAN WART: That is what we are after.

THE CHAIRMAN: Do you know of any actual case in which a doctor has been criticized for discussing something of the nature that you mention since this oath of secrecy has been asked for?

DR. ROBERTS: Mr. Chairman, what I would like to say is that we feel that the doctor, whose main duty is the provision of personal medical services to people, owes a primary allegiance to the people he is treating. It is true he may be an employee; he may be an employee of many different types -- in this case, an employee of Government, but although he is an employee of Government, we feel his primary duty must be to the people he is treating and, as we see it, an oath of secrecy of

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this type could be used -- it may not be the intention to do so -- but it could be used to interfere with the doctor-patient relationship in a manner detrimental to the patient and therefore detrimental to the public interest. That is a summary of the way we feel about it.

THE CHAIRMAN: Well, I would like you to spell it out a little more if you can, and in those areas where you say it would be detrimental: one, about a doctor in possession of information?

DR. KELLY: Mr. Chairman, it occurs to me we have an immediate example here. Suppose the members of this Royal Commission became particularly interested in the details of the Cottage Hospital system which is unique in this Province, and the best spokesman to inform you of the details of the Cottage Hospital system is the President of this Division, Dr. Twomey, who has for many years worked in that system. He could say, "I am unable by the oath of secrecy which I have been obliged to sign to answer your questions about the Cottage Hospital system", and that might be detrimental to the investigations which this Royal Commission is undertaking.

THE CHAIRMAN: I would not want to project this as a legal ruling, but I am afraid your example is incorrectly taken. The Commission has power to have people answer -- an over-riding power by statute to get information. I mean, with regard to your example, there happens to be an answer to it. It may not be an effective answer to all things. A doctor is answerable by subpoena to come before this Commission and testify.

DR. ROBERTS: Mr. Chairman, one can concoct

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DR. [illegible]: Mr. Chairman, [illegible]

an answer for it: it may be a bit far-fetched, but not out of the question: there may be a situation in a community where the well water was unhealthy, and there might be a potential typhoid fever situation. The Cottage Hospital doctor, as I understand it, would have to go to his superiors in the Department of Health, inform them of this, and, say, that action was not taken at an appropriate time -- and I don't suppose action is not taken by governments appropriately -- but perhaps it would not be quick enough, and he could not get up on the rooftops and shout it out and tell the people what the situation was.

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Whereas the private practitioner in some situation would be able to take a little more direct action. This may be a far-fetched example, but it is the type of thing ---

THE CHAIRMAN: No, I don't think it is far-fetched. The next question is: what is the sanction behind the oath? What can happen to you, what can happen to a doctor under the legislation, under the edict, as you call it, if somebody thinks he has violated that undertaking?

DR. ROBERTS: It is a civil matter, I suppose. You have taken the oath as a civil servant, and if he violates the oath, I don't know what rules would pertain there.

COMMISSIONER BALTZAN: Reading further on, Dr. Baird, I would like the Commission to be informed a little bit on a statement here. "We believe that conditions of private practice will attract more doctors than a Government salaried service", and more particularly, "and thus will provide a better quality of care". A doctor is a doctor no matter where he is; the sick should be treated, etc. Is it that private practice has an inducement to better care because of there being more means for a personalized service and not as it may be taken otherwise, because of the size of one's income? A salaried man gives one kind of quality of service and a private man gives another quality of service. What is the reason for it? Why is it that the profession would prefer - as you say here, they are attracted to private practice?

DR. BAIRD: Well, sir, I think that the person who is doing private practice and is directly

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DR. BAIRD: Well, sir, I think that the person who is doing private practice and is directly

1 responsible for the patient himself and has a control over
2 his own practice and to whoever comes to him for care, and
3 he can control the amount, the duration and the length.
4 I think this is different from the doctor who is on
5 salary. I think it is human nature in time when you are
6 on salary, that it is conducive. We are not against the
7 doctors being on a salary in such a scheme, but we are
8 against them being in a Cottage Hospital with no induce-
9 ments, where it tends to make a lessening in the work load,
10 and there is a desire to go into the larger centres, and
11 this, we feel, is not best for the patient necessarily or
12 for the doctor.
13 COMMISSIONER BALTZAN: In other words, would
14 stay in the retail business rather than do it wholesale.
15 May I, Mr. Chairman, go on with one other
16 point here? "In more recent times, individual doctors
17 have brought almost the full range of modern medical
18 science to Newfoundland", and you mention these specialties.
19 These, I take it, were things that were pioneered by indi-
20 viduals before others took over the need. In other words,
21 these things, vascular surgery, were primarily brought
22 here because of the pioneering of individuals, not by an
23 organization?
24 DR. BAIRD: This is not completely so, but
25 it is in a large measure so.
26 COMMISSIONER BALTZAN: There is one other
27 point. Perhaps I will pass on until I come to it.
28 COMMISSIONER VAN WART: I have two or three
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questions I would like to ask. First of all, do the

[illegible] in the Cottage Hospital plan consider themselves

civil servants?

DR. BAIRD: Well, they have to now, sir. They did not at one stage. They felt they were on a contractual basis with the Department of Health, but now they feel they are under the Act, and that is why the oath of secrecy is taken.

COMMISSIONER VAN WART: As to this contractual agreement, do they pay dues into the civil service organization or are they on the outside - pensions, and so on?

DR. ROBERTS: As I understand it, these doctors are civil servants, but they are what is called here, generally, unestablished civil servants, and as far as I can understand it, these men have many of the disadvantages of civil servants with few of the advantages; they are not pensionable, and I don't imagine they belong to any civil service organization as such. That is my understanding. I might be wrong.

COMMISSIONER VAN WART: What type of contract do they sign? For a certain period of time?

DR. ROBERTS: I don't know about that.

COMMISSIONER VAN WART: Do they come under the Civil Service Act?

DR. ROBERTS: I understand they certainly do come under the Civil Service Act.

DR. McGRATH: Sir, I just want to say that if there are any questions of fact in regard to organization, I would be very glad to answer them.

THE CHAIRMAN: Thank you very much, Doctor. Have you any statement or any facts that you want to give

[illegible] Labs within the Department of Health, but now [illegible]

[illegible] VAN WART: As to their contract [illegible] and agreement, do they pay dues into the civil service [illegible] or are they on the outside - pensions, and so on?

Mr. [illegible]: As I understand it, these [illegible] are the civil servants, but they are what is called [illegible] unestablished civil servants, and so far [illegible] understand it, these men have many of the disad[illegible] [illegible] with few of the advantages. [illegible] unfortunate, and I don't imagine they become [illegible] permanent as such. There is my [illegible] understanding. I may be wrong.

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Mr. [illegible]: I don't know about that.

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VAN: Thank you very much, Doctor. [illegible] any f[illegible]

us as to this oath of secrecy? What does it mean?

DR. McGRATH: Yes. Essentially it means that any civil servant is not supposed to gossip outside on any civil service matters. I don't think anyone would say that is an unreasonable provision. But how doctors came into this - it was not the desire of anybody to impose this on the doctors, but the doctors in Cottage Hospitals were paid on the receipts in certain areas, and that worked a hardship, because in bad times the receipts in these areas went down, and the Government decided to put them on salary, and it was based on a period of the previous three years. In the case of certain men who were allowed outside practice of various kinds, no change was made in the contract, but as these contracts fell in a new appointment would be made on the various salaries. I think they are now about $14,000 and $12,000. Where there was a man in a district where there could be a lot of insurance work or workmen's compensation, he was allowed this area of private practice and retained it until he changed the contract and went away. But the new man didn't get some of the favourable conditions that the old people did.

It was pointed out that under the Act the statute required it, and that being so, we had no alternative but to insist on it.

In regard to the objections against the oath, now, there is some substance in the objection against it. I can't imagine any case where a doctor would be restricted in his function. I can't conceive that there might be some interference; I can't see it myself, and I don't think my colleagues or myself can quote a case of that

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happening. It is suggested that the doctor whose business is to look after the water supply would be the first to do so, and it would be quite impossible to see a situation where he wouldn't.

COMMISSIONER VAN WART: Do all the other health officers have to take the oath?

DR. McGRATH: In certain areas a man may be a full-time salaried man. For the purpose of the Civil Service Act, he is allowed to take certain outside fees, but if his salary is regarded as a full-time salary he is not allowed to. But a man may be paid $200 a month to look after certain areas in a private capacity; these men are not civil servants. There are two types of civil servants. There is the established civil servant, who is a man in a regular post on a salary and pension, and there is the unestablished civil servant who may be only on for a certain period of time or the post is not pensionable. But he is a civil servant, and he actually has the disadvantages of the civil service without having the advantages. Does that cover your point?

COMMISSIONER VAN WART: Yes. One further question. Has this worked a hardship when you get doctors come into the hospital plan?

DR. McGRATH: Not that I know of. I have interviewed people, and since the objection to the oath came up - we have always brought it up so far, and I am sure nobody has found anybody from the old country who made objection; in fact, the attitude was: Why do you talk about it? We don't have any objection to it. The objections have come from the people mostly who do not take

[illegible]

[illegible]

[illegible]

the oath, and with one outstanding exception, we have no objection at all from the people who do take it.

COMMISSIONER BALTZAN: Mr. Chairman, referring to Chapter 78, "The growth in the number of doctors in Newfoundland from 154 in 1950 to 275 in 1961 is largely derived from the increase in the number of doctors in private practice areas". Now, perhaps the Minister would be in a better position, if I may impose upon him, to answer this. On the contrary, has there been difficulty in obtaining and any reticence on the part of others to fill posts in your Cottage Hospitals where it is so-called full-time?

DR. McGRATH: I don't quite get the question.

COMMISSIONER BALTZAN: I am sorry, it is my fault. I see here a statement that shows that there has been quite an increase in the number of private practice physicians, which would seem to be an attractive feature.

THE CHAIRMAN: Private practice areas.

COMMISSIONER BALTZAN: This means private practice; is that so?

DR. BAIRD: Yes.

DR. McGRATH: I think by private practice, it is like St. John's, Cornerbrook and so on. I think the question is that doctors are more - I would have to answer that in two parts. In the cities and towns I don't think there is any difficulty. I don't think we have any trouble really in staffing our major institutions. It is outside where the trouble is, and outside I don't see any difficulty in getting Government salaried physicians. It is my opinion that it is easier to get people when a

COMMISSIONER RAINZAN: Mr. Chairman, refer

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definite salary is offered them. In many cases we in the Department have had to make the necessary contacts to get people for the private practice. But I think it is not the difference between the private practice and the Government practice; it is the question of isolation. Where you have a really isolated area, I think it is easier to get a man where you have a Government salary to pay him, and in some areas the private practice man could not make a living in some of the places where we want the men.

COMMISSIONER BALTZAN: Paragraph 37: "A limitation on earnings has been imposed for paediatricians", and it goes on. But the point is, are paediatricians those in private practice or those in full-time practice in Cottage Hospitals, as you call it here?

DR. BAIRD: The only paediatricians are in private practice, sir, in St. John's.

COMMISSIONER BALTZAN: So it is imposed on physicians in private practice?

DR. McGRATH: I am sorry, I don't want to interfere here, but I think this refers to their earnings and payment from the Government for their work in the hospitals. It doesn't impose any limitation on his private practice, it imposes a limitation on his Government practice.

DR. ROBERTS: That is true now, Mr. Chairman. There may come a day ---

DR. McGRATH: I think the paragraph here is unintentionally not quite correct. The limitation has been imposed on the amount of earnings in hospitals on

[illegible] between the private practice and the government practice; it is the question of isolation. Where you have a really isolated area, I think it is [illegible] to pay him, and in some areas the private practice man [illegible] want the men.

COMMISSIONER RAITZAN: Paragraph 27: "A [illegible] and it goes on. But the point is, are paediatrician [illegible] areas in private practice or those in full-time public [illegible] in voluntary hospitals, as you call it here?

DR. BAILEY: The only paediatricians are in private practice, sir, in St. John's.

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Government practice.

COMMISSIONER VAN WART: Did I understand you to say that all paediatricians are in private practice?

DR. BAIRD: Yes, sir.

COMMISSIONER VAN WART: No paediatricians in the Children's Hospitals under the health scheme?

DR. McGRATH: Not salaried ones, sir.

DR. ROBERTS: There are no Children's Hospitals in this Province, sir. There are facilities in the hospitals for paediatrician staff.

COMMISSIONER VAN WART: There is no paediatrician Cottage Hospital?

DR. ROBERTS: No.

THE CHAIRMAN: Correct me if I am not putting it correctly. This question of paediatricians arises because of the program of paying for all services of children up to 16?

DR. BAIRD: In hospitals, yes.

THE CHAIRMAN: Now, for those the Government allows the paediatrician an initial maximum of $14,000?

DR. McGRATH: Correct.

THE CHAIRMAN: Plus 25% of accrued fees in any one year plus what he may make in private practice outside the hospital. That is the true situation?

DR. McGRATH: That is the exact situation.

[illegible]

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THE CHAIRMAN: Plus 25% of accrued fees in any one year plus what he may make in private practice outside the hospital. That is the true situation?

DR. McGRATH: That is the exact situation.

COMMISSIONER GIRARD: Dr. Baird, I understand that you recommend that nursing schools be established in Cornerbrook, and subsequently in central Newfoundland. What are the minimum requirements for the establishment of a school of nursing in a hospital in this Province?

DR. BAIRD: I don't think I can answer that question.

COMMISSIONER GIRARD: Maybe the Minister would like to answer this.

DR. McGRATH: I don't think it is governed specifically by statute, but I think the situation is this, that if a hospital is able to train its nurses to a recognized standard, and the nursing board will examine these people, it can establish a nursing school.

DR. MILLER: There are no statutory requirements, but I would say generally speaking the requirements follow about the average of the rest of Canada, better than some, not as good as others.

THE CHAIRMAN: These are the standards set by whom, by the Registered Nurses' Association?

DR. MILLER: This has not come up, because there has been no new training school on the cards, so to speak, recently, but it would be set by the Newfoundland Registered Nurses' Association.

COMMISSIONER GIRARD: What bed capacity do you anticipate that these hospitals will have?

DR. MILLER: Between one and two hundred beds each. We would not suggest a training school, as is in existence in some parts of Canada now, for 60 or 70 beds.

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COMMISSIONER GIHARD: What bed capacity do you anticipate that those hospitals will have?

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THE CHAIRMAN: You say you recommend that nursing schools be established. By whom?

DR. MILLER: It would be by the governors of the particular hospitals. It is conceivable that a hospital might be a Government hospital, as is the general hospital here. There are two others in St. John's. The hospital at Cornerbrook will be under a board. By the governing agency of the hospital.

THE CHAIRMAN: That is what this recommendation means?

DR. MILLER: As I take it, yes.

COMMISSIONER STRACHAN: There is one question I would like to ask on the last paragraph of the summary, wherein it is suggested that a medical school should be established in St. John's. Is this a serious suggestion for the immediate future. Is the Province having any trouble placing its students at the present time in medical colleges? There has been a suggestion that the Dalhousie Faculty might be enlarged, and apparently that is where most of your graduates come from. Would the enlargement of Dalhousie in any way satisfy the need for positions in the Province?

DR. BAIRD: We feel that this is a long-term program, sir, and we would like to see the planning started and all the facts that are brought up by you in your question would be considered to see if this is feasible, and on what basis. For instance, we have been given to understand that under certain circumstances there might be a possibility of foundations on the mainland, and perhaps in the United States, might just be interested

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[illegible]

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[illegible]

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in putting up a physical plant, the actual buildings. Well, if this sort of thing were available, then the cost to the Province of maintaining it would be a more reasonable figure, and this all might become possible. We are not sure about these things, but we understand that these are possibilities, and if they are possible we would like to have it pursued.

DR. McGRATH: Mr. Chairman, will you please restrain me if I appear to be entering too much in this. That is an actual fact. It has had the consideration of the Government. It is under active consideration at the present time, not as an immediate thing, because we do not feel that we can start next Thursday morning, but we have been in touch with universities in the United States and Canada who have medical schools. I would say at the present time, I couldn't commit Government to a positive policy because I don't think we know quite enough yet about it. There is no doubt that the addition to Dalhousie will be a great help to us here, but certainly the possibility of the opening of our own medical school is very active, and under very active examination.

THE CHAIRMAN: Is this idea, I mean to say, is it something with some element of Provincial pride involved in it, or is it a matter of practical necessity?

DR.McGRATH: The question really before us that we are considering now in discussion with the Medical Association, is really to see is this a good thing to do? I don't think we know that yet. If it is a good thing to do and we feel that it is, it will certainly be pursued with activity, but I don't think we have reached the stage

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[illegible]

DR. MACNAUGH: Mr. Chairman, will you please

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Association [illegible]

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[illegible]

yet of being certain of that.

DR. ROBERTS: I just wanted to say that it is not fair of us to ask Dr. McGrath to say what we mean in the brief, but it certainly was asked was this a serious suggestion, and it certainly is serious. The suggestion, we think, warrants serious study, and our basic reason for introducing it is that we feel that the Province that wants doctors is going to have to make its own doctors. If we don't make doctors we have to import them, and our basic thought is that we have to make our own doctors if we are going to have enough.

COMMISSIONER McCUTCHEON: But this recommendation, you say, is merely for the information of the Commission, and is one of two or three which are going to be the subject of discussion in the Province?

DR. ROBERTS: Just to introduce a lighter note, I think Dr. McGrath need not feel bashful about speaking, because he is not only Minister of Health, but he is a member in good standing of the Newfoundland Medical Association.

COMMISSIONER VAN WART: The question of the Cottage Hospital. The Cottage Hospital Plan is unique in Canada, and I would like to have a little more information about them. As I understand their purpose, why they are put there, but firstly there are some things in their operation. How do the patients get into the Cottage Hospital? There are no doctors in the communities, do the patients just walk up to the hospital, or are they referred by doctors, or how do they get to the Cottage Hospital for treatment?

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DR. TWOMEY: The patients have full rights and privileges to come to the out-patient department of the Cottage Hospital, where they are seen by a doctor who will admit them if he thinks it necessary, when the opportunity arises, depending on the patient's condition, or in areas where there is a private practitioner or medical health officer, he has the right and privilege to refer them as a patient to the Cottage Hospital for admission.

COMMISSIONER VAN WART: Do the Cottage Hospital doctors go out to see patients and so on?

DR. TWOMEY: Yes, I think there is only one Cottage Hospital where the doctors do not go out and do domiciliary work.

COMMISSIONER VAN WART: In the hospital you have an out-patient first. Now, in the in-patient part of the hospital, you have medical, surgery, obstetrics and what else?

DR. TWOMEY: Paediatrics, a laboratory, x-ray units.

COMMISSIONER VAN WART: Your x-rays, you have no trained radiologists in these, you rely on a technician, do you?

DR. TWOMEY: Yes, in one area in central Newfoundland we have a radiologist who is stationed at Gander Cottage Hospital, and he visits ---

COMMISSIONER VAN WART: You have a travelling radiologist?

DR.TWOMEY: Only for two of the Cottage Hospitals. I might be open to correction there, I think

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DR. TWOMEY: Only for two of the Cottage hospitals. I might be open to correction there, I think

on the west coast the radiologist does occasionally visit other hospitals.

DR. McGRATH: He acts as a consultant, but he does not visit as regularly as your man does.

COMMISSIONER VAN WART: Do you have a central bureau, where you can send films in for opinions and that sort of thing?

DR. TWOMEY: It varies in each area. In my Cottage Hospital I refer them to the radiologist in Gander, 50 miles away, and he visits my hospital once a week, where he reads these films. The chest x-rays are sent to the west coast sanitorium.

COMMISSIONER VAN WART: What about consultant problems and bedside diagnostic cases? Does a consultant come to your hospital?

DR. TWOMEY: Two or three times a year a consultant travels across the country and visits the Cottage Hospitals with two or three days in each hospital depending on the amount of work available at that time.

COMMISSIONER VAN WART: Are you under an obligation to carry out what he says, or is it left to your judgment?

DR. TWOMEY: It is left to our judgment, but in my case I carry out his ---

COMMISSIONER VAN WART: But are you obliged to do what he tells you to?

DR. TWOMEY: No.

COMMISSIONER VAN WART: You still have medical freedom of judgment?

DR. TWOMEY: Yes.

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MR. VAN WART: Do you have a central bureau, where you can send films in from [illegible]

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COMMISSIONER VAN WART: What about occupational problems and bedside diagnostic cases? Does a consultant come to your hospital?

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COMMISSIONER VAN WART: But are you obliged to do what he tells you to?

DR. TWOMBY: No.

COMMISSIONER VAN WART: You still have [illegible]

DR. TWOMBY: Yes.

DR. BAIRD: A large number of patients are referred to the general hospital in St. John's and the west coast hospital for diagnosis and surgical treatment.

COMMISSIONER VAN WART: And those patients return to the Cottage Hospital after the diagnostic or surgical procedure is carried out?

DR.BAIRD: Yes.

COMMISSIONER VAN WART: Is your Cottage Hospital considered as a public health centre for preventive medicine procedures and so on?

DR. TWOMEY: In most cases it is. Vaccinations, routine chest x-rays ---

COMMISSIONER VAN WART: Polio innoculations?

DR. TWOMEY: Yes, in some areas. It varies in particular areas. In some areas you might have a private practitioner in a few of the Cottage Hospital areas, and he carries out that particular work. In other areas, where you haven't got a medical practitioner, the Cottage Hospital would undertake that particular work.

COMMISSIONER BALTZAN: In the Cottage Hospital area, do other physicians, who are not on the staff of a Cottage Hospital, have the privileges in that hospital to look after patients that they find necessary to send to the hospital, or do they come under the aegis of the staff in that hospital?

DR. TWOMEY: Usually they are under the staff in that particular hospital. There have been exceptions. My hospital was one, where the doctor in private practice in the community could use the hospital to look after a case.

COMMISSIONER VAN WART: Is your testimony

Hospital considered as a public health center for preventive medicine procedures and so on?

DR. TWOMEY: In most cases it is. We have

COMMISSIONER VAN WART: Only in certain areas?

DR. TWOMEY: Yes, in some areas. For example in particular cases. In most cases the client has a private practitioner in, for if the client is special areas, and he requires our help, medical work, we do

COMMISSIONER VAN WART: In the clinics

Hospital area, do other physicians, who are not on the staff of a Kitsapo Township, have the privilege in the hospital to have other patients under their care, or are to send to the hospital, or do they come under the jurisdiction of the staff in that township?

DR. TWOMEY: Usually they are made-up into staff in their particular hospital. There have been exceptions. My surgical man too, were the doctor in private

[illegible]

COMMISSIONER BALTZAN: What is the rule?

DR. TWOMEY: It varies. In the majority of cases you have not got private practitioners in close proximity to the hospital, so it could be to the patient's disadvantage for that man to come a long distance to do a delivery, or anything else.

COMMISSIONER BALTZAN: Conditions being equal then, he could have privileges?

DR. TWOMEY: Yes. I think there would be various factors involved in deciding whether the man would have privileges or not to work in these hospitals. I think if the man was able and capable, I am sure he would be given the privileges.

COMMISSIONER BALTZAN: In other words, there is no rule against it?

DR. TWOMEY: No.

COMMISSIONER FIRESTONE: I would like to address my first question to Dr. Twomey in his position as President of the Newfoundland Division of the Canadian Medical Association. I take it, sir, that you and the executives of your Association are familiar with the Terms of Reference of the Royal Commission, as contained in the Order in Council PC 883-61?

DR. TWOMEY: Yes.

COMMISSIONER FIRESTONE: May I quote from this Order in Council, and draw your attention to one particular statement, and I quote: "The Commission is requested to recommend such measures consistent with the constitutional division of legislative powers in Canada as the Commissioners believe will ensure that the best

possible health care is available to all Canadians". I would like to draw your attention to the word "all", because this means availability of universal coverage. And the second thing I would like to quote to you is a statement which was made at the preliminary hearing of the Royal Commission, held in Ottawa on September 27th 1961, and I quote from the opening statement of our Chairman: "The view appears to be developing, taken into account increasingly by Governments, that opportunity for good health is a right possessed by all, and should become available in one form or another to every citizen of Canada". Now, sir, do you and your colleagues agree with these two principles quoted, and I will repeat, one, the availability of health services to all Canadians, and that includes all citizens of your Province of Newfoundland, and two, the opportunity for good health is a right possessed by all and should become available in one form or another to every citizen of Canada, and that includes everybody in Newfoundland. Do you and your associates agree with these two principles?

DR. TWOMEY: We do.

COMMISSIONER FIRESTONE: Thank you very much. May I turn to your brief, and perhaps if I understood you correctly, sir, I should address these questions to Dr.Baird?

DR. TWOMEY: Thank you.

COMMISSIONER FIRESTONE: My first question relates to page B of your summary, the second paragraph, and you say in the second paragraph that you are recommending a method of prepayment of the costs of medical

the Royal Commission, held in Ottawa on September 24, 1961, and I quote from the opening statement of the Chairman: "The view appears to be developing, taking into account increasingly by Governments, that opportunity for good health is a right possessed by all, and should be available in one form or another to every citizen of Canada". Now, sir, do you have additional copies of these two pamphlets available? Will those, one, availability of medical services to all Canadians, and two, the opportunity for good health as a right possessed by all and should become available in one form or another to every citizen of Canada, are what I believe everybody in Newfoundland, Mr. and Mrs. Smith, agree with these two principles.

DR. TUCKER: We do.

COMMISSIONER PICCLIONE: Thank you very much. May I turn to your brief, and perhaps if I understood you correctly, sir, I should address some questions to Dr. Reimer?

MR. TUCKER: Thank you.

relates on page 8 of your summary, the second paragraph, and you say in the second paragraph that you are recommending

services with Government assistance. My question is, are you in favour of a comprehensive medical service plan, and if you are, are you in favour of a tax-supported plan, plus contributions by those who can afford it?

DR. ROBERTS: If I have heard you correctly, and I am not sure that I have, I would say yes, at least I think that is what I would say within the framework of the C.M.A. Statement of Principles.

COMMISSIONER FIRESTONE: I repeat the first part of the question. Are you in favour of a comprehensive medical service plan?

DR. ROBERTS: Yes.

COMMISSIONER FIRESTONE: Are you in favour of this plan when some of the sources of revenue for the payment of this plan will come from tax revenue, and some by those contributing, who can afford to pay for them?

DR. ROBERTS: Yes.

COMMISSIONER FIRESTONE: I turn now to the next paragraph, the top paragraph on page C of your summary. You say here that it will be necessary for governments to subsidize voluntary plans for prepayment. What kind of voluntary plans for prepayment do you have in mind? Do you have in mind non-profit schemes? Do you have in mind co-operative schemes? Would that cover, for example, coverage provided by commercial insurance carriers?

COMMISSIONER BIRKSTONE: I report the first part of the question. Are you in favour of a [illegible]

DR. [illegible]

COMMISSIONER BIRKSTONE: Are you in favour of this plan when some of the members of [illegible] by those contributions, who can afford to pay for them?

DR. ROSENDAL: Yes.

COMMISSIONER BIRKSTONE: [illegible]

summary. You say there that it will be necessary for government to subsidize voluntary plans for [illegible]. What kind of voluntary plans for [illegible] do you have in mind? Do you have in mind non-profit [illegible]? Do you have in mind co-operative [illegible]? Would that [illegible] coverage provided by commercial insurance [illegible]

DR. BAIRD: That is not primarily our thought, that it would be commercial carriers. We feel that if a non-profit doctor-sponsored scheme could be worked into this arrangement, that we would be in favour of this.

COMMISSIONER FIRESTONE: The next statement suggests that these schemes would not be self-liquidating or self-paying, and they would require a subsidy: what formula would you suggest should be employed in determining the subsidy, and I would like to be helpful to you: we are really genuinely interested in your views, and if you find some of the questions difficult, we would be very happy if you or your executive would consider them further and give us the information at a later stage in written form.

DR. BAIRD: To lead into your question, if we could on an actuarial basis decide how many people there are in a local area in this scheme we propose, and that there would be 'X' dollars required to finance it on the methods we have suggested, then we would feel a local body made up of prominent citizens in the local area should be allowed to decide what level of premium patients could pay on a single or family basis. Up to now they have been paying in the neighbourhood of $10 for their Cottage Hospital subscription rate, and perhaps this is a fair fee that could be expected of the majority of the people in the local area other than the indigents. On the other hand, because of local economy it may be possible they would be able to afford, say, $15 or $20 rather than $10, or in some other areas they may not be

suggests that these schemes would not be self [illegible]

the subsidy, and I would like to be informed [illegible]

are really seriously interested [illegible]

happy if you or your executive [illegible]

and give us the information [illegible]

DR. BAILEY: [illegible] or questions [illegible]

we could go on so scattered [illegible]

there are in a local area [illegible]

that there would [illegible] be [illegible]

on the methods we have suggested [illegible]

local body made up of [illegible]

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now they have been [illegible]

their doctors [illegible]

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of the people in the local area [illegible]

on the other hand, because of local economy [illegible]

rather than $10, or in some other areas they may [illegible]

able to afford more than $5. However, we feel this contribution from the people is important, that it should be based on their economic ability to pay, and after you have decided how much the people can afford to pay in the way of a premium, then you come to what proportion the Provincial and Federal authorities should divide. That, I think, we could not answer at this time.

COMMISSIONER FIRESTONE: I take it you would be prepared to take questions of this type under advisement and let us know your views at a subsequent time?

DR. BAIRD: Appropos of that, we should say we feel that our Provincial Government is probably contributing as much to health at the moment as they are likely to be able to in the future under present economic conditions, and perhaps if we assume that to be a fact, and they continue to contribute what they are contributing out of general revenue, it would not be too difficult to arrive at what balance would be necessary from the Federal Government.

COMMISSIONER FIRESTONE: I presume you are making this observation as a personal observation and not from an examination you and the executive have carried out, and presumably you will have an opportunity to do so when you make a supplementary submission to us?

DR. BAIRD: Yes.

COMMISSIONER FIRESTONE: Thank you very much. I would like to pursue one aspect of the answer a little further: you were talking about this scheme being ministered by local boards, and you elaborate in paragraph

[illegible] to affect more than 3%. However, we feel that [illegible] consideration from the people at large, that we should [illegible]

[illegible] have decided now that the [illegible] to pay in the way of a premium, then you [illegible] what proportion [illegible]

I think, we could not answer at this time.

COMMISSIONER BURSTEN: I take it, [illegible] would be prepared to take questions of this type [illegible] advisement and let us know your views at a subsequent [illegible]

MR. BURNS: [illegible] we feel that our Provincial Government is probably [illegible] carrying as much to health as the [illegible] to be able to [illegible] tions, and perhaps if we [illegible] they continue to contribute what they are [illegible] out of general revenue. It would not be [illegible] arrive at what burden we can be necessary from the Federal Government.

COMMISSIONER FITZGERALD: [illegible] making this discussion to me a [illegible] from an examination [illegible] sub, and presumably you will have an opportunity to do so when you make a supplementary submission [illegible]

COMMISSIONER FITZGERALD: Much [illegible] more. I would like to [illegible] a little information you were talking about [illegible] being [illegible] by local people, and you also [illegible]

85 how these local boards would operate; it is paragraph 85 on page 23. Do I understand these are private boards?

DR. BAIRD: Yes, sir.

COMMISSIONER FIRESTONE: Boards of private citizens?

DR. BAIRD: Yes, sir.

COMMISSIONER FIRESTONE: Do I understand from your proposal that you are suggesting that governments should make funds available to these private boards, which are monies collected by governments from the taxpayers, to be paid out by private citizens as they see fit; is that the suggestion?

DR. BAIRD: Yes, sir.

COMMISSIONER FIRESTONE: Do you think this is a sound principle, that the Government collects taxes and then turns them over to private citizens for them to spend?

DR. BAIRD: I think if it is a non-profit organization, and if the Government has full authority to do auditing procedures, I think it is a reasonable proposal.

COMMISSIONER FIRESTONE: Well, I take it, then, that you are also proposing a full public control over these local bodies?

DR. BAIRD: Well, we would like to encourage the autonomy of the local bodies as much as we can. We think this is an aspect of life that has to be encouraged not only in health, but in all the other aspects. We have heard this morning that attempts along this line have been performed in the past, and they are continuing to be

[illegible] boards would operate. It is [illegible]

[illegible]

COMMISSIONER FRIEDMAN: Boards of [illegible]

[illegible]

COMMISSIONER FRIEDMAN: In [illegible]

from your proposal that you are suggesting that [illegible] months should make funds available to these private [illegible] which are monies collected by government from [illegible] payers, to be paid out by private citizens as they see fit; is that the suggestion?

DR. [illegible]: Yes, [illegible].

COMMISSIONER FRIEDMAN: Do you [illegible] and then turns them over to private citizens for them to spend?

DR. [illegible]: I think [illegible] is a [illegible] organization, and if the Government was [illegible] to do auditing procedures, I think it is a reasonable proposal.

COMMISSIONER FRIEDMAN: Well, I [illegible] them, that you are also [illegible] over these local bodies?

DR. FRIEDMAN: Well, we would like [illegible] the autonomy of the local bodies as much as we can. We think this is an aspect of life that has to be encouraged not only in health, but in all the other agencies. We have heard this morning that absenteeism along this line have been

encouraged, and we feel this is an extra aspect. Furthermore, we feel the economy of a locally operated thing, with everyone interested in the cost to them personally, would probably be saving money in the long run.

COMMISSIONER FIRESTONE: Are you in favour of local autonomy per se, or are you also agreeable to local autonomy that is publicly controlled?

DR. BAIRD: I am not sure I understand that.

COMMISSIONER FIRESTONE: Well, I will be very happy to help you. Are you in favour of local autonomy because you want local citizens to run the show and distribute tax money, or do you feel there is anything wrong with the Government wanting to control, to see how this tax money is actually spent? Would your organization object to public control of these private councils which you have recommended?

DR. BAIRD: I think if you have local autonomy and control you are more likely to get a fair means test arrangement, for instance, to decide who is an indigent and who is not, rather than a central department in the capital of the Province making some sort of blanket ruling as to whether you are above or below this level. We sort of contemplate whereby the local people could decide what was a fair level of income to expect them to pay premiums and things like that. Does that answer your question?

COMMISSIONER FIRESTONE: Let me put the question differently. Would you be in favour of having such local boards not being under Provincial control even

[illegible]

[illegible]

[illegible]

though they be spending Provincial and Federal tax money?

DR. BAIRD: I think they would have to be under some control.

COMMISSIONER FIRESTONE: Well, "some control" is which control? Is it Government control or not Government control, and if it is not Government control, what other control do you have?

DR. BAIRD: Primarily an independent commission.

COMMISSIONER FIRESTONE: An independent commission set up by whom, sir? Would you like to take the question under advisement and let us know your views at a later stage?

DR. BAIRD: Yes, sir.

COMMISSIONER FIRESTONE: As I said earlier, we are really interested in your genuine views and not in a rash answer. Can we leave it at that?

DR. BAIRD: Yes.

COMMISSIONER FIRESTONE: Thank you very much.

THE CHAIRMAN: Perhaps before you leave the area of local control as we are discussing it, how would the doctor be paid under such a program?

DR. BAIRD: Well, we have some suggestions in here, sir, about the details of that, but perhaps not all of them. I think we have felt the doctor should be paid by this board. He would submit his bills to this board.

THE CHAIRMAN: On what basis?

DR. BAIRD: On a fee for service basis.

DR. BAIRD: I think they would have to be

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DR. BAIRD: Primarily an independent commission.

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THE CHAIRMAN: Perhaps before you leave the area of local control as we are discussing it, how would the doctor be paid under such a program?

DR. BAIRD: Well, we have some suggestions in here, sir, about the details of that, but perhaps not all of them. I think we have felt the doctor should be paid by this board. He would submit his bills to this board.

THE CHAIRMAN: On what basis?

DR. BAIRD: On a fee for service basis.

THE CHAIRMAN: Who would set the fee?

DR. BAIRD: We have in our own organization a schedule of fees which we have used in the past in negotiations with our Provincial Government, and I think it is a fairly official document, and I think it is subject to review at periodic intervals, and I think this would also be incorporated.

THE CHAIRMAN: You mean be arrived at by negotiation between the Medical Association and the Government?

DR. BAIRD: Yes.

THE CHAIRMAN: Not this local body that you would have administering it?

DR. BAIRD: No, I don't think so.

COMMISSIONER McCUTCHEON: You speak of a voluntary plan, and I take it that means you are not advocating a plan which it is compulsory for all persons to join?

DR. BAIRD: Yes.

COMMISSIONER VAN WART: Would you give me the percentage of the population that are insured with Blue Shield and other voluntary agencies?

DR. BAIRD: I think approximately 60,000.

COMMISSIONER VAN WART: 60,000 in Newfoundland?

DR. BAIRD: Yes.

COMMISSIONER VAN WART: That would be what percentage of the population?

DR. BAIRD: Perhaps 48, so it would be one-eighth.

THE CHAIRMAN: Who would set the fee?

DR. BAIRD: We have in our own organization a schedule of fees which we have used in the past in negotiations with our Provincial Government, and I think it is a fairly official document, and I think it is subject to review at periodic intervals, and I think that would also be incorporated.

THE CHAIRMAN: You mean be arrived at by negotiation between the Medical Association and the Government?

DR. BAIRD: Yes.

THE CHAIRMAN: Not this Board but that you would have administering it?

DR. BAIRD: No, I don't think so.

COMMISSIONER MOCUTCHEON: You speak of a voluntary plan, and I take it that means you are not advocating a plan which it is compulsory for all persons to join?

DR. BAIRD: Yes.

COMMISSIONER VAN WART: Would you give us the percentage of the population that are insured with Blue Shield and other voluntary agencies?

DR. BAIRD: I think approximately 60,000.

COMMISSIONER VAN WART: 60,000 in Newfoundland?

COMMISSIONER VAN WART: That would be what percentage of the population?

DR. BAIRD: Perhaps 4%, so it would be one-

COMMISSIONER VAN WART: 12½%?

DR. BAIRD: Yes, I think so.

COMMISSIONER FIRESTONE: If I may proceed, I am referring now to your section 2 on page C of your summary, in which you discuss mental health service for the Province of Newfoundland. This morning the Minister of Health and the Deputy Minister of Health pointed out to us that one of the difficulties in providing increased services in the field of mental health was that matter of an inadequate number of psychiatrists in your Province. Has your Association any suggestions to make on how to attract more psychiatrists to the Province of Newfoundland, or what you, yourself, could do to train more psychiatrists in the Province?

DR. WILLIAMS: Mr. Chairman, it is a two-part question, the first part of which deals with the attraction of the psychiatric school in the Province of Newfoundland. I think it can be looked upon in many ways, and if you look at our brief you will see at the moment all our psychiatric patients are being treated in one hospital, which gives little diversification in terms of interest in the whole field of mental health. We are inadequately supplied with psychiatrists. We have at the present time no units in general hospitals. We have one psychiatric out-patient clinic in the general hospital which is run by psychiatrists in full-time Government service.

My feeling in terms of recruitment is that one of the important things would be more satisfactory physical facilities for the treatment of psychiatric patients, and the more diversification of these facilities

I am referring now to your section 2 on page 6 of your summary, in which you discuss mental health services in the Province of Newfoundland. This morning the Minister of Health and the Deputy Minister of Health pointed out to us [illegible] inadequate number of psychiatrists in your Province. [illegible] more psychiatrists to the Province of Newfoundland, or what you, yourself, could do to train more psychiatrists in the Province?

DR. WILLIAMS: Mr. Chairman, it is a two-fold question, the first part of which deals with the training of the psychiatric school in the Province of Newfoundland. I think it can be looked upon in many ways, and if you look at our brief you will see at the moment all our psychiatric patients are being treated in one hospital, which gives little diversification in terms of interest in the whole field of mental health. We are inadequately supplied with psychiatrists. We have at the present time no units in general hospitals. We have one psychiatric out-patient clinic in the general hospital which is run by psychiatrists in full-time Government service.

My feeling in terms of recruitment is that one of the important things would be more satisfactory [illegible]

in terms of out-patients' clinics and general hospital units and so on. I feel if this were so the number of psychiatrists which may be attracted would perhaps increase.

I think there are other factors such as -- and again it fits in with diversification of services -- but I think the question of types of patients -- for example, in this Province the treatment of non-psychotic patients in terms of hospital facilities is nil.

So, I feel when one looks at all these factors, I think in other areas where these facilities are present, they are liable to attract many more psychiatrists.

As regards the training of psychiatrists, I think as well this is a problem we in Newfoundland, I believe, in the last few years, have been perhaps much more fortunate in that we have, in fact, gone from practically no trained people whatsoever -- certainly in the last 10 years -- to 6 trained psychiatrists now -- or, 6 certified psychiatrists, and in the next few years we hope this will increase. I think, again, one of the problems here is attracting people into the specialty of psychiatry. If we could attract them, I think we could get them in for training, but I think it fits in with attraction into this Province.

COMMISSIONER FIRESTONE: Thank you, that is very helpful. May I now turn to section 3 on page D of your summary, the second paragraph, in which you outline the deficiencies of general hospital beds, convalescent hospital beds and beds for the chronically ill.

I think there are other factors such as -- and again it fits in with diversification of services -- but I think the question of types of patients -- for example, in this Province the treatment of non-psychotic patients in terms of hospital facilities is nil.

So, I feel when one looks at all these -- are present, they are liable to attract many more psychotics -- cases.

As regards the training of psychiatrists, I think as well this is a problem we in Newfoundland, I believe, in the last few years, have been perhaps much more fortunate in that we have, in fact, gone from practically no trained people whatsoever -- certainly in the last 10 years -- to 6 trained psychiatrists now -- or, 6 certified psychiatrists, and in the next few years we hope this will increase. I think, again, one of the problems here is attracting people into the specialty of psychiatry. If we could attract them, I think we could get them in for training, but I think it fits in with attraction into this Province.

COMMISSIONER FIRESTONE: Thank you, that is very helpful. May I now turn to section 3 on page D of your summary, the second paragraph, in which you outline the deficiencies of general hospital beds, comparing hospital beds and beds for the chronically ill.

I wonder whether we could have some advice and information from you as to what can be done to increase the utilization of hospital beds in terms of patient-use per bed through improved home nursing care facilities?

DR. BAIRD: Well, I think we can all think of cases in our own individual practices -- which puts it on a personal rather than a general basis -- where if we had a more adequate convalescent arrangement, whether at home or in hospital, that this would have speeded the turnover in beds, and especially to people who have things like healing of fractures, or perhaps a wound that has not healed properly and really is not requiring much in the way of active treatment, but really you don't want to send them to an area where there is no doctor; these people need some care. Whether these people could be put in a convalescent hospital, or whether they could be treated at home under boarding house arrangements if they are from out of town, with an organization like the Victorian Order of Nurses, I would think anything like this we can get that would increase our turnover of our active beds would be greatly appreciated.

COMMISSIONER FIRESTONE: This is a constructive answer and may I compliment you on the answer. Would it be too much to ask you to elaborate this point in a supplementary submission?

DR. BAIRD: Not at all.

COMMISSIONER FIRESTONE: Thank you. I would like to turn now to the fifth paragraph on page D of your summary in which you recommend that the Royal Commission study the possibility of establishing a

DR. MAILE: Well, I think we can all think of cases in our own individual practices -- which puts on a personal rather than a general basis -- where if we had a more adequate convalescent arrangement, whether at [illegible]

turnover in beds, and especially to people who have things like healing of fractures, or perhaps a wound that has not healed properly and really is not requiring much in the way of active treatment, but really you don't want to send them to an area where there is no doctor; there people need some care. Whether these people could be put in a convalescent hospital, or whether they could be treated at home under nursing home arrangements if they are from out of town, with an organization like the Visiting Order of Nurses, I would think anything like this we can get that would increase our turnover of our active beds would be greatly appreciated.

COMMISSIONER FIRESTONE: This is a rhetorical question and may I compliment you on the answer. Would it be too much to ask you to elaborate this point in a supplementary submission?

DR. MAILE: Not at all.

COMMISSIONER FIRESTONE: Thank you. I would like to turn now to the fifth paragraph on page D

Federal lending agency to assist in such construction with the repayment of loans over long term, and again this is perhaps a difficult question that can best be answered in a subsequent written submission, but to put the question on record could you spell out for the Royal Commission how such a plan would work? Do you have in mind direct loans by a Federal agency to a Provincial agency, to independent hospital boards or commissions, or perhaps guarantees to private financial institutions similar to the provisions under the National Housing Act? Furthermore, are you familiar that under the National Housing Act authority exists to provide loans or to guarantee loans for the construction of residences for nurses associated with hospitals and universities, and would the construction and building of such residences not assist in increasing the number and availability of para-medical personnel, and if it does wouldn't it perhaps ease somewhat the burden on the doctor or doctors which they are now carrying in the Province, enabling him to provide better quality of service? Can you take this under advisement and let us have your views?

DR. BAIRD: We would like to very much.

COMMISSIONER FIRESTONE: Thank you. May I now turn to paragraph C on page F of your summary, the supply of professional personnel. Could you comment on the effectiveness of the Provincial financial assistance program to young men studying medicine? Are you satisfied this program is working well?

DR. BAIRD: Yes, sir, we are.

COMMISSIONER FIRESTONE: Have you any views

loans by a Federal agency to a Provincial agency, to Municipal hospital boards or commissions, or perhaps guarantees to private financial institutions similar to the provisions under the National Housing Act? Furthermore, are you familiar that under the National Housing Act authority exists to provide loans or to guarantee loans for the construction of residences for nurses associated with hospitals and universities, and would the construction and building of such residences not assist in increasing the number and availability of para-medical personnel, and if it does wouldn't it perhaps ease some what the burden on the doctors or doctors which they are now carrying in the areas, compelling them to provide

[illegible]

ment and let us have your views?

DR. BAIRD: We would like to very much.

COMMISSIONER FRECKTON: Thank you. May I now turn to paragraph C on page F of your summary, the supply of professional personnel. Could you comment on the effectiveness of the Provincial financial assistance program to young men studying medicine? Are you satisfied this program is working well?

DR. BAIRD: Yes, sir, we are.

as to whether the program could be expanded or improved?

DR. BAIRD: Well, I am not in a position to know whether there are more people applying to the Department of Health for financial assistance to study medicine that are at present getting grants. I was under the impression that if they applied they were given the grant.

COMMISSIONER FIRESTONE: Have you any views about grants for graduate studies?

DR. BAIRD: Well, at the present time, in certain circumstances, the Department of Health and the Government of Newfoundland, are providing monies for completion of post-graduate studies, especially in those fields where they feel there is an inadequate supply of trained personnel.

COMMISSIONER FIRESTONE: Has the Newfoundland Division of the Canadian Medical Association any recommendations to make with respect to this, or are they happy to leave things to the Provincial Department of Health?

DR. BAIRD: I think we have mentioned the medical school, and this should be actively pursued, and I think we will leave that for a subsequent submission to your Commission.

COMMISSIONER FIRESTONE: Thank you, sir. Have you been obtaining the Newfoundland grants for medical research?

DR. BAIRD: Do you mean Federal health grants for medical research?

COMMISSIONER FIRESTONE: Well, medical research from any source, which would include Federal grants as well?

that are at present getting grants. I was under the impression that if they applied they were given the grant.

COMMISSIONER FIRESTONE: Have you any [illegible] about grants for graduate students?

Dr. WALD: Well, at the present time, in certain circumstances, the Department of Health and the completion of post-graduate studies, especially in those fields where they feel there is an inadequate supply of trained personnel.

COMMISSIONER FIRESTONE: Has the National Division of the Canadian Medical Association any representations to make with respect to this, or are they [illegible] leave things to the Division of Department of Health

Dr. WALD: I think we have mentioned the medical school, and this should be strongly urged, and I think we will leave that for a subsequent submission to your Commission.

Have you been considering the Montsouland grants for medical research?

Dr. WALD: Do you mean federal health grants for medical research?

[illegible]

research from any source, which would include Medical [illegible]

DR. BAIRD: I am not in a position to answer.

DR. McGRATH: To a very limited extent. I believe Dr. Miller could give you it exactly. Some have been refused, I know, and one or two of these projects have been carried through: one in particular on radiation, on the St. Lawrence there was help by the Federal Government with practically no limitation as they considered it to be an emergency. I think Dr. Miller could comment on that.

DR. MILLER: Mr. Chairman, I must say that we have received no money under research grants. The idea was that this wasn't left to the individual provinces; the money was pooled and the money for this, certain mining hazards, came out of one of our ordinary grants, not a research grant. There was one other we put up which was not accepted.

COMMISSIONER FIRESTONE: Would the Newfoundland Medical Association include in its supplementary submission recommendations with respect to the research grant for medical research in Newfoundland?

DR. BAIRD: Yes, sir.

THE CHAIRMAN: Could you say what it is now?

DR. BAIRD: Very minimal.

THE CHAIRMAN: I suppose you have to have the research facilities before you have access to the grants?

DR. BAIRD: Yes.

COMMISSIONER FIRESTONE: I presume if you made the supplementary proposal you may also want to tell us what kind of medical facilities you would be anxious or interested in establishing and developing in Newfoundland.

DR. BAIRD: Yes.

COMMISSIONER FIRESTONE: What it would cost and how you would go about it.

DR. BAIRD: Yes.

COMMISSIONER FIRESTONE: If I may now turn for a moment to page 24, paragraph 87. You speak in that paragraph about the desirability of charging "a small

[illegible] Association g-ants. The idea was that this wasn't left to the individual provinces, the money was pooled and the money for this, certain mining bounds, came out of one of our ordinary grants, not a research grant. There was one other we put up which was not accepted.

COMMISSIONER FITZSTONE: Would the Newfoundland Medical Association include in its supplementary [illegible] recommendations with respect to the research grant for medical research in Newfoundland?

DR. BAIRD: Yes, sir.

THE CHAIRMAN: [illegible]

THE CHAIRMAN: I suppose you have to have the research facilities before you have access to the [illegible]

DR. BAIRD: Yes.

COMMISSIONER FITZSTONE: I presume if you made the supplementary proposal you may also want to tell us what kind of medical facilities you would be anxious or interested in establishing and developing in Newfoundland.

DR. BAIRD: Yes.

COMMISSIONER FITZSTONE: What it would cost and how you would go about it.

DR. BAIRD: Yes.

COMMISSIONER FITZSTONE: If I may now turn for a moment to page 24, paragraph 87. You speak in that paragraph about the desirability of changing "a small

deterrent fee". What would you visualize that fee to be and what would be its objective?

DR. BAIRD: Well, from talking to many Cottage Hospital doctors at the moment, they run very large out-patient clinics, and they say up to about a third of the people they see in their clinics are perhaps in the nature of trivial complaints, and that because of this factor we feel that the principle of a deterrent to minimize this would make the doctors' time more economical and useful.

COMMISSIONER FIRESTONE: We are just interested in finding out how the principle would be applied, and if you are not in a position to give an answer at the moment, we would be very happy to have it at a subsequent time. But we would be interested to know what would be charged and what it is designed to achieve. Thank you.

I turn now to paragraph 97 on page 26. We heard this morning from the Minister of Health that while you have been fortunate in attracting a number of doctors from Great Britain and Ireland, that the source of supply has been, if not drying up, reduced; you are not getting as many men as you have been getting in the earlier periods. Now, if this difficulty of supply is increased from this source, would you in your Division of the Canadian Medical Association be in favour of immigrant doctors coming from other countries other than the United Kingdom and Ireland, provided that they meet the standard of professional competence required by your medical board, and provided further that these doctors would be prepared to practise for a specified number of years in outlying

[illegible] third of the people they see in their clinics are perhaps in the nature of trivial complaints, and that because of this factor we feel that the principle of a deterrent to minimize this would make the doctors' time more economical and useful.

[illegible] in finding out how the principle could be applied, and if you are not in a position to give an answer at the moment, we would be very happy to have it at a subsequent time. But we would be interested to know what would be changed and what it is designed to achieve. Thank you.

I turn now to paragraph 97 on page 20. We have been fortunate in attracting a number of doctors from Great Britain and Ireland, that the source of supply has been, if not drying up, reduced; you are not getting as many men as you have been getting in the earlier periods. Now, if this difficulty of supply is increased from this source, would you in your Division of the Canadian Medical Association be in favour of immigrant [illegible] Kingdom and Ireland, provided that they meet the required of professional competence required by your medical board, [illegible]

areas designated by the Department of Health, similar to the arrangement you have now in operation under the medical scholarship plan where young boys obtaining loans practise a minimum of two years in these outlying areas?

DR. BAIRD: We would, sir.

COMMISSIONER FIRESTONE: I now turn to paragraph 103, page 28, where you talk about the desirability of a medical school in Newfoundland, and we have been rather interested to hear the Minister of Health's advice that this matter was under active consideration. I was just wondering whether these investigations that are under way might be finalized in the next, say, six to nine months sufficiently to enable the Government and the medical profession to come to conclusions, and, if so, could we have an indication of what those conclusions may be, and could we have the financial aspects as compared to the other? That is perhaps a question to be directed to the Minister.

DR. McGRATH: I can't give you a clear answer on that. I can't say that within a given time we would be able to give a clear decision. But, of course, it would affect both the Federal Government and the University. Of course, if we had to have a medical school it would be under the control of the Federal Government.

COMMISSIONER FIRESTONE: Can we leave it that if you are in a position to come to some conclusion in the next nine-month period, that this information be available to us? There will be a concluding set of hearings in Ottawa some time in the second half of next

department of Health, similar to the arrangement you have now in operation under the [illegible]

a minimum of two years in those outlying areas?

DR. BAIRD: We would, sir.

COMMISSIONER [illegible]: I now turn to page 103, page 28, where you talk about the desirability of a medical school in Newfoundland, and we have been rather interested to hear the Minister of Health's advice that this matter was under active consideration. I was just wondering whether these investigations and in what way might be finalized in the next, say, six to nine months sufficiently to credit the Government and the medical profession to come to a conference, and, if so, could we have a [illegible] of what these conditions may be, and could we have the financial aspects as compared to the cost? That is perhaps a question to be directed to the Minister.

DR. MORGAN: I can't give you a clear answer on that. I can't say when within a year that we would be able to give a clear decision. But, of course, it would affect both the Federal Government and the University. Of course, if we had to have a medical school it would be under the control of the Federal Government.

[illegible]

that if you are in a position to come to some conclusion in the [illegible] nine-month period, that this information be available to us? There will be a conference set up [illegible] in Ottawa some time in the second half of next

year, and perhaps on that occasion, if not sooner, such information could be made available to us, if it is available.

DR. McGRATH: We could do so.

COMMISSIONER FIRESTONE: And this applies to your Department, sir, as well as the Newfoundland Division of the Canadian Medical Association.

Now, may I come back to my concluding question, and that is a question of the financial implications of the numerous recommendations which are contained in the report. You have gone further than many other submissions, and I would like to congratulate you, Mr. President, and your executive for having tried to assess what some of these things would cost if one were to go ahead with them. Would it be possible to add up all these figures which are dispersed throughout the report, supplemented by those where you haven't made an estimate, and to come forward with what this would cost and where the money would come from?

DR. BAIRD: Yes, sir.

COMMISSIONER FIRESTONE: Thank you very much, sir.

THE CHAIRMAN: This brief will be Exhibit 23.

--- EXHIBIT NO. 23: Submission of the Newfoundland Medical Association.

THE CHAIRMAN: Thank you very much, Dr. Twomey, and your executive. It has been a very fruitful

DR. MACPHATTER: We could do so.

COMMISSIONER FERGUSON: And this applies to your Department, sir, as well as the Newfoundland Division of the Canadian Medical Association.

Now, may I come back to my concluding question, and that is a question of the financial implications of the numerous recommendations which are contained in the [illegible], and I would like to congratulate you, Mr. President, on your executive for having tried to assess what some of these things would cost if one were to go ahead with them. Would it be possible to add up all these figures, which are dispersed throughout the report, supplemented by those where you haven't made an estimate, and to come forward with what this would cost and where the money would come from?

[illegible] SIGNOR FINNEGAN: Thank you very [illegible].

THE CHAIRMAN: This [illegible] will be inserted [illegible].

--- EXHIBIT NO. 69: Comments of the Newfoundland [illegible]

THE CHAIRMAN: Thank you very much, Dr.

discussion and submission.

Then we will hear the submission of the Newfoundland Dental Society.

SUBMISSION OF THE NEWFOUNDLAND DENTAL SOCIETY

Appearances: Dr. E.P. Kavanagh
Dr. H.J. Hann
Dr. J.M. Darcy
Dr. B.L. Bowden

--- EXHIBIT NO. 24: Submission of the Newfoundland Dental Society

DR. KAVANAGH: Mr. Chairman, members of the Royal Commission, ladies and gentlemen, may I, as President of the Newfoundland Dental Society, extend to you a most hearty welcome to St. John's. We hope your stay will be pleasant and useful. Dr. H.J. Hann will give you our presentation. He has agreed to answer any questions you wish to ask.

PAGE 1

Dr. J.M. Dwyer
Dr. B.L. Bowden

--- EXHIBIT NO. 24: Submission of the Newfoundland Dental Society

DR. MACDONALD: Mr. Chairman, members of the Royal Commission, ladies and gentlemen, my I, as President, most heartily welcome Dr. Dwyer's. We hope your stay will be pleasant and useful. Dr. B.C. Dean will give you our presentation. He has agreed to answer any questions you wish to ask.

SUBMISSION

of the

NEWFOUNDLAND DENTAL SOCIETY

to the

ROYAL COMMISSION ON HEALTH SERVICES

St. John's, Nfld.

October 12, 1961.

SUMMARY

The Newfoundland Dental Society in this submission attempts to trace the development of dental services during the last twenty years. An inventory of existing dental facilities and service is submitted, and the dental health problem is presented, as having geographical, economic and sociological aspects.

The recommended solutions to the problem are listed as:

(i) Establishment of three regional dental health units - each under the direction of a regional dental health consultant.

(ii) Early implementation of Fluoridation of Water.

(iii) Intensive dental education programmes.

(iv) Expansion of the dental care programme for children.

(v) Establishment of financial incentives for rural practice.

(vi) Establishment of a Scholarship and Student Loan Fund.

John's, Nfld.

The Newfoundland Dental Society in its submission attempts to trace the development of dental services during the last twenty years. An evaluation of existing dental facilities and service is submitted, and the dental health problem is presented, as having geographical, economic and sociological aspects.

The recommended solutions to the problem are listed as:

(i) Water - each under the direction of a regional dental health commissioner.

(ii) Early implementation of fluoridation of water.

(iii) [illegible]

(iv) Expansion of the dental care programme for children.

(v) Establishment of financial incentive for rural practice.

(vi) Establishment of a scholarship and student loan fund.

Mr. Chairman and members of the Royal Commission on Health Services.

1. The Newfoundland Dental Society welcomes the opportunity to submit its views in respect to dental health services, and offers its fullest co-operation to the Commission in fulfilling its objectives.

2. The Newfoundland Dental Society is a corporate member of the Canadian Dental Association and its objectives are outlined in Appendix A.

3. Development of Dental Services

Dental Services developed slowly in Newfoundland, and in the years prior to 1945 throughout the Colony (outside of four larger towns) dental services were largely emergency oral surgery and prosthetic services, the former generally performed by the local medical officer or public health nurse. In 1951, with a population of 361,406, there were 16 dentists in practice; in 1956, with a population of 415,074, there were 37 dentists; and in 1961 (est.) population of 470,000, there were 44 registered dentists. In the ten years, 1951-61, the number of communities served by resident dentist has increased from eight to seventeen communities. Both distribution of dentist and the dentist to population ratio have improved. With this increase in dental personnel, it has been possible to make available more dental services, particularly conservative dentistry and preventative dental care. Appendix B.

4. Existing Dental Facilities and Services

A. Facilities:

and members of the Royal Com-

The Newfoundland Dental Society welcomes the opportunity to submit its views in respect to dental health services, and offers its fullest co-operation to the Commission in fulfilling its objectives.

member of the Canadian Dental Association and its objectives are outlined in Appendix A.

Dental services developed slowly in Newfoundland and in the years prior to 1945 throughout the Colony (outside of four larger towns) dental services largely emergency oral surgery and prosthetic services, the former generally performed by the local medical officer or public health nurse. In 1951, with a population of 361,406, there were 16 dentists in practice; in 1956, with a population of 415,074, there were 37 dentists; and in 1961 (est.) population of 470,000, there were 44 registered dentists. In the two years, 1951-61, the number of communities served by resident dentist has increased from eight to seventeen communities. Both distribution of dentist and the dentist to population ratio have improved. With this increase in dental personnel, it has been possible to make available more dental services, particularly conservative dentistry and preventative dental care.

Appendix B.

(i) The administrative office of Director of Dental Service.

(ii) Two Government sponsored dental clinics operated by full time dental staff.

(iii) Forty-one individually operated general dental practices.

B. Services:

(i) A Government sponsored dental health programme offers a limited free service to school children of ages five, six and seven years in communities where dentists are available.

(ii) Out port medical doctors in cottage hospitals and nursing stations offer emergency dental treatment to people within the surrounding area.

5. Dental Health Problems

In Newfoundland the greatest problem in dental health today is the control of rampant dental caries. To this end the profession is devoting its energy, its skill, and its knowledge to bring tooth decay and related dental disease within manageable limits of control. Three factors influence the high incidence of dental caries - they are: geographic, economic and sociologic factors.

Geographically, the island of Newfoundland with its population scattered over a long coast line presents almost insurmountable difficulties in providing health services to a large segment of the population. Isolation, lack of communication, and lack of the other amenities of life has made dental practice location in many areas quite unattractive to the dental

operated by full time dental staff.

(iii) Forty-one privately operated general dental

(i) A Government sponsored dental health programme

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(ii) Out post medical doctors in outreach hospitals

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Isolation, lack of communication, and lack of the other amenities of life has made dental practice location

practitioner. Hence, while there exists a great need for dental practitioners in many outlying areas, at the same time the type of dental service demanded is of an emergency nature which is generally performed by the area medical doctor.

Economically, the financial burden of dental health service is beyond the capacity of many familites. An economy based largely on casual labour is very vulnerable to economic fluctuation. Hence, the characteristically large Newfoundland family (4.6), with a variable earning capacity (seasonal employment) very often has only the basic essentials to sustain livelihood, and is unable to provide themselves with proper dental care. It is this segment of society that looks to our profession, to our government and to this Commission for guidance and assistance to elevate their health standards in a way that will not compromise their pride and native independence.

Sociological reasons in addition to educational factors, determine why the demand for dental services is often disproportunate to the need. There would appear to be a lack of appreciation for sound dental health, and a low priority on dental services, especially among the lower income and lower educated groups in our society.

Recruitment to the dental profession poses a great problem for the profession and as well, for those planning health services. While members individually have endeavoured to encourage young men to enter the dental profession, our success in recruitment has not been gratifying. The chief obstacles to successful recruitment

medical doctor.

Economically, the financial burden of dental health service is beyond the capacity or means of [illegible] often has only the bare essentials to maintain life [illegible] and is unable to provide themselves with proper dental care. It is this segment of society that looks to our profession, to our government and to this Commission for guidance and assistance to alleviate their dental [illegible] dards in a way that will not compromise their [illegible] and native independence.

Manpower resources in addition to [illegible] factors, determine the demand for dental services is often disproportionate to the need. There seems appears to be a lack of appreciation for sound dental health, and a low priority on dental services, especially among the lower income and lower educated groups in our country.

Recruitment to the dental profession poses a great problem for the profession and as well, for those [illegible] have endeavoured to encourage young men to enter the dental profession, our success in recruitment has not been [illegible]

would appear to be:

(i) The high cost of dental education abroad, due to lack of training facilities for dental personnel in Newfoundland.

(ii) The high cost of establishing and equipping a dental office, upon graduation.

(iii) Unfavourable competition from industry and other professions which offer greater finpancial reward with less investment.

(iv) Lack of vocational guidance at the high school level.

6. Recommended Solutions

It is our opinion that the chief objective of the dental profession should be to render the best possible dental service to the people of Newfoundland. Further, this high quality service can best be rendered under a well organized, properly developed, and efficiently administered master plan for dental care. We submit that the requirements be:

(i) The establishment of three regional dental health units (and later subdivisions of each) in Eastern, Central and Western Newfoundland.

(ii) That each regional dental health unit be under the direction of a dentist properly qualified in dental public health, with the status of regional dental health consultant.

(iii) That a comprehensive Dental Survey be undertaken in each region (and later in each subdivision) to establish:

(a) a dental caries index.

(i) The high cost of dental education around, i.e. to lack of training facilities for dental personnel in Northwestern

general office, upon graduation,

(ii) Unfavorable competition from industry and

general towns with less investment.

(iv) Lack of vocational guidance at the high school

It is our opinion that the chief obstacle to the dental profession should be to render the best possible dental service to the people of Northwestern. Further, this high quality service can best be rendered under a well organized, properly developed, and efficiently administered master plan for dental care. We submit that the requirements for:

(i) The establishment of three regional dental health units (and later subdivisions of each)

That each regional dental health unit be headed by the direction of a dentist properly qualified in dental public health, with the support of regional dental health committees.

(ii) That a comprehensive Dental Survey be made in each region (and later in each subdivision) to establish:

(b) the incidence of malocclusion and periodontal disease for children in each region.

(iv) That preventative dental care programmes be developed on the basis of this survey, and be directed by the regional dental consultant.

At present the Provincial Department of Health sponsors a Children's Dental Health Scheme which is administered by the Director of Dental Services. However, the profession views with concern the possible adverse effects upon the Scheme that would result should the Director's office become suddenly vacant, through premature retirement or departure of the Director. It is our view that every effort should be made to assist the Director of Dental Services with additional dental consultants and that the present administration be more broadly based.

7. Fluoridation of Water

Among all known health measures the one that stands out as offering measurably striking benefits is the fluoridation of drinking water. This health measure has been universally accepted as a convenient, inexpensive, absolutely safe method whereby the tooth decay rate can be reduced by about 60 per cent. Our Provincial Department of Health has on repeated occasions recommended to the municipalities the earliest possible implementation of water fluoridation. The profession is concerned that the teeth of thousands of children should be deprived of the benefits of fluoridation, while municipal officials fail to acquaint themselves of the benefits of this proven

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7. Fluoridation of Water

Among all known health measures the one that stands out as outstanding measurably benefits is the fluoridation of drinking water. This health measure has been universally accepted as a convenient, inexpensive, absolutely safe method whereby the tooth decay rate can be reduced by about 60 per cent. Our Provincial Department of Health has on repeated occasions recommended to the municipalities the earliest possible implementation of water fluoridation. The profession is concerned that the teeth of thousands of children should be deprived of the benefits of fluoridation, while municipal officials fail to acquaint themselves of the benefits of this proven

health measure. Therefore, we suggest that the Government of Newfoundland make mandatory the fluoridation of all water supplies in towns and municipalities which have public water supply.

8. Dental Health Education

The second approach to preventative dental care is through dental health education. Widespread educational efforts must be undertaken to acquaint people, parents and children with the importance of dental health and with the means of attaining it. This intensive dental health education programme should be under the direction of the dentist trained in public health, and the programme should be carried out utilizing the services of the dental hygienist, the dental practitioner, the teacher and lay organizations.

9. Children's Treatment Programmes

Ideally, complete dental care ought to be available to all children up to the age of sixteen years, and we believe that this could be best accomplished through prepayment and post payment dental plans, voluntary group insurance or through public funds when economic circumstances dictate. Therefore, the profession supports in principle the present incremental dental care programme operating in this Province which covers five, six and seven year olds and we suggest that periodically new age groups be added until all children up to the age of sixteen years are covered. It is hoped that future expansion of the present plan will include such specialists' services as those rendered by orthodontists. It is presumed that expansion of the

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present plan will depend upon: (i) financial resources available: (ii) dental personnel to further implement the plan.

The profession believes that any children's dental care plan should be based on the accepted principle that the doctor-patient relationship is at its best when the patient has the freedom of choice of practitioner, and the practitioner enjoys the same right of choice. We are also of the opinion that remuneration on the basis of fee for service results in a high quality of service. Further, that the co-operation of the profession and the success of any dental care programme will depend to a large measure upon a fair and equitable basis for remuneration for the service provided.

10. Personnel and Recruitment

At a time when there is great demand for trained medical and dental personnel throughout the whole of Canada, underdeveloped areas and areas of doubtful economic future will remain unattractive to young graduates. To be realistic, we submit that a dentist will be attracted to certain outlying areas in Newfoundland for the following reasons: (i) family connectinns or to satisfy pioneering spirits; (ii) greater financial incentives than are available elsewhere. It might be assumed, then, that dentists might be expected to locate in rural areas if the financial incentives were attractive. Such incentives might include - the provision of dental equipment (ownership retained by Government) located in the cottage hospital or medical clinic with little or no rent, with the prospect of

the plan.

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10. Incentives and encouragement

At a time when there is great demand for trained medical and dental personnel throughout the whole of Canada, underdeveloped areas and areas of doubtful economic future will remain unattractive to young graduates. To be realistic, we submit that a dentist will be attracted to certain outlying areas in Newfoundland for the following reasons: (i) family connections or to satisfy pioneering spirits; (ii) greater financial incentives than are available elsewhere. It might be assumed, then, that dentists might be expected to locate in rural areas if the financial incentives were attractive. Such incentives might include - the provision of dental equipment (ownership retained by Government) located in the cottage hospital or medical

assistance from hospital staff. A guaranteed annual income to be augmented by private practice would, no doubt, be attractive to the new graduate. Finally, when the Province enters the tax field in 1962 certain tax concessions, especially on equipment purchases, might have attractive appeal.

The recruitment of young Newfoundlanders to the dental profession could be encouraged through establishment of Scholarship Fund with would make available, annually, large scholarships for high academic standard. In addition there is a great need for the establishment of a Student Loan Fund from which long term, non-interest bearing, loans might be available to students who might prefer to finance their own education, thereby remaining free to accept competitive opportunities.

Conclusion

The need for leadership in all walks of life is greater today than ever before. So in the dental profession, we recognize our responsibility to provide leadership in the development of the highest possible standard of health for the people of this country. That leadership will be most productive in an environment where enlightened government policy is designed to assist rather than dominate the profession. It is in this social structure that the dental practitioner prefers to render his finest service.

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APPENDIX A

The Newfoundland Dental Society

The Newfoundland Dental Society evolved from the former Newfoundland Dental Association. The new Society was formed and incorporated in 1955. The Society supervises the ethical and professional conduct of all its forty-three members registered in the Province.

The objectives of the Newfoundland Dental Society as outlined in its Memorandum and Articles of Associations are:

(i) To cultivate and promote the art and science of Dentistry.

(ii) To elevate and sustain the professional character and education of the dentist, and further the unity and harmony among its members.

(iii) To disseminate knowledge of dentistry and dental discovery.

(iv) To enlighten and to direct public opinion in relation to oral health and advance scientific dental service.

(v) To have cognizance of, to safeguard, and to advance the common interests of the members of the profession.

(vi) To hold conventions, publish dental journals and treatises.

The Newfoundland Dental Society, though a corporate member of the Canadian Dental Association, is not the official dental licensing body - this function comes within the authority of The Newfoundland Dental Board.

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APPENDIX A[1]

Officers representing the Newfoundland Dental Society at hearings of the Royal Commission on Health Services:

President - Dr. E.P. Kavanagh,
St. John's, Nfld.

Dr. H.J. Hann,
St. John's, Nfld.

Dr. J.M. Darcy,
St. John's, Nfld.

Dr. B.L. Bowden,
St. John's, Nfld.

Dr. M.J. Maguire,
Gander, Nfld.

Dr. K. Obrazcova,
Corner Brook, Nfld.

Dr. W.J. O'Driscoll,
St. John's, Nfld.

Members of the Newfoundland Dental Society other than the listed representatives might wish to speak at the Commission hearings. It is hoped that their wish would meet with the pleasure of the Chairman.

APPENDIX B[1]

Dentist to population ratio for all the provinces of Canada

Province	Registered Dentists	Dentist Population Ratio
Newfoundland	44	1/10,929
Nova Scotia	196	1/3,710
New Brunswick	120	1/5,175
Prince Edward Island	31	1/3,323
Ontario	2,513	1/2,423
Quebec	1,388	1/3,679
Manitoba	286	1/3,143
Saskatchewan	196	1/4,643
Alberta	431	1/2,977
British Columbia	662	1/2,429
TOTAL	5,865	

Canadian average - 3,037 population to 1 dentist.

Province	Population	Dentist
Newfoundland	-	-
Nova Scotia	196	1/3,710
New Brunswick	110	1/5,175
[illegible]	32	1/3,325
[illegible]	2,513	1/2,425
Quebec	[illegible]	[illegible]
Manitoba	286	1/3,143
Saskatchewan	[illegible]	[illegible]
Alberta	[illegible]	[illegible]
British Columbia	551	1/2,420
TOTAL	3,865	

Canadian average - 3,057 population to 1 dentist.

APPENDIX B^2

Dentist to Population Ratio

for

Newfoundland 1951-1961

Year	Registered Dentist	Population	Ratio D/P
1951	16	361,406	1/22,587
1956	37	415,074	1/11,218
1961	44	470,000(est.)	1/10,929

Canadian average - 1/3,037.

Children under 15 years

1956	168,910
1961	194,000 (est.)

Newfoundland annual total population increase - 12,000.

APPENDIX B3

Distribution of Dentist to Population on basis of 10 census districts, not counties.

District	1956 Total Population	Urban	1961 Dentist
No. 1	171,213	102,574	24
No. 2	23,980	8,037	1 (?)
No. 3	21,675	5,792	0
No. 4	19,631	5,314	2
No. 5	35,215	26,706	8
No. 6	33,738	25,222	3
No. 7	38,209	6,586	1
No. 8	40,629	3,260	2
No. 9	19,970	1,761	1 (?)
No. 10	10,814	---	0

Those who live in cities, towns and villages over 1000 population are classified as URBAN.

Census Districts

No. 1 St. John's, Bay de Verde, Bay Roberts, Carbonear, Harbour Grace, Mount Pearl, Placentia, Wabana (Bell Island).

No. 2 Burin, Fortune, Grand Bank, Marystown, St. Lawrence.

No. 3 Belloram, Burgeo, Port-aux-Basque, Ramea.

No. 4 Stephenville.

No. 5 Corner Brook, Deer Lake.

No. 6 Winsor, Grand Falls.

No. 7 Glovertown, Greenspond, Wesleyville.

No. 8 Lewisporte, Change Islands.

No. 9 St. Anthony, Englee.

No. 10 Labrador.

Distribution of Dentist to Population on basis of 10

District	Population	Urban	Dentist
No. 1	171,213	102,574	2
No. 2	23,580	8,057	1 (?)
No. 3	21,675	5,792	0
No. 5	35,215	26,706	8
No. 6	33,738	25,222	7
No. 8	40,629	3,260	2
No. 10	10,014		

Those in five towns, towns and villages over 1000 population are classified as URBAN.

Census districts

No. 1 St. John's, Bay de Verde, Bay Roberts, Carbonear, Harbour Grace, Brigus, Cupids, Clarenville, Port Rexton, Lawn, Hare Bay, Musgrave Harbour, Lewisporte.

No. 2 Stephenville.

No. 3 Corner Brook, Deer Lake.

No. 5 Windsor, Grand Falls.

No. 6 [illegible]

No. 8 St. Anthony, Englee.

No. 10 Labrador.

THE CHAIRMAN: Dr. Hann, in the matter of your dental care program for children, to what extent is it carried on as an adjunct of the school program?

DR. HANN: We do not have a school program as such where the clinic is located within the school itself. At the moment the Government sponsors a scheme which renders free treatment to children aged 5 to 7, kindergarten to Grade 2, and these children come to the office of the private practitioner.

THE CHAIRMAN: We heard and we know that in great areas of Newfoundland there is no municipal government as we know it in other parts of Canada. Does the same apply to schools, the organization of schools or the school boards?

DR. HANN: I think the school boards are directly responsible to the Department of Education and they don't ---

DR. McGRATH: The school boards are responsible for the nominees, I think.

THE CHAIRMAN: Is there any plan in Newfoundland where these school boards have school dentists which carry on programs under the jurisdiction of these boards?

DR. HANN: To the best of my knowledge, there isn't.

COMMISSIONER BALTZAN: There is an interesting thing here in regard to fluoridation, to read on page 4, number 7, the last portion of it. "The profession is concerned that the teeth of thousands of children should be deprived of the benefits of fluoridation, while municipal officials fail to acquaint themselves of the benefits

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COMMISSIONER MAITZAN: There is an interesting thing here in regard to fluoridation, to read on page 4, number 7, the last portion of it. "The profession is concerned that the teeth of thousands of children should be neglected by the dentists in Newfoundland, with consequent pal officials fail to acquaint themselves of the benefits

of this proven health measure. Therefore, we suggest that the Government of Newfoundland make mandatory the fluoridation of all water supplies..." I understand that in one Province in Canada this came as a referendum before the people and it was rejected. Now, in what way can one make it mandatory upon a Government to do that which the people might reject, although it is approved, say, by your own Department of Health and by your profession at large? How can that be done?

DR. HANN: It is my understanding that the municipality has the right to fluoridate and has the right to obtain the view of the citizens. I am surprised that there should be a Provincial referendum of this nature. I think maybe it was a municipal referendum, and there have been quite a number. As a matter of fact in some of the Provinces there is already legislation established to the effect that there must be 65% in favour of fluoridation in order for the municipality to fluoridate. The precedent for this recommendation has been set in the Republic of Ireland just last year. This fluoridation was made mandatory and it is due recognition of the wisdom of the Irish that this recommendation is submitted.

THE CHAIRMAN: Doctor, you speak of municipalities, but we have been hearing that you have no municipal government as such.

DR. McGRATH: Oh, yes, we have begun to have them in recent years, but as I explained this morning they are still struggling.

THE CHAIRMAN: So that what you say is that the Provincial Government should take this in hand and put in the fluoridation program on its own responsibility?

DR. HANN: Yes, we believe that there are a great number of municipal councils, shall we say, who are reluctant to assume the responsibility to implement this, and we say that we would be very happy for the Department of Health to undertake this responsibility, or the Government, and we believe that the Government has on previous occasions recommended to municipalities that fluoridation is safe, economical and sound, so that we feel that the

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central government here should take the initiative.

COMMISSIONER BALTZAN: Do you think, sir, that the problem has not been solved through insufficient measures for educating the public in relation to fluoridation?

DR. HANN: I think that it will probably be many, many years before we can bring the population to the point where they will vote in a large majority in favour. As a person who believes the scientific evidence in support of this measure, I would personally have to take this stand.

COMMISSIONER STRACHAN: Mr. Chairman, I think it would be quite reasonable to assume that where there is no municipal government, there would be no communal water supply.

DR. McGRATH: That is almost true, but not entirely. There are communal water supplies where there are no municipalities, but these are small and would be incapable of fluoridation.

THE CHAIRMAN: Any further questions, Dr. Strachan?

COMMISSIONER STRACHAN: Yes, there are a few points I would like to have cleared up in my mind, and I am sure in the mind of the Commission. Are there any dental facilities in Cottage Hospitals? Is there any provision made for the accommodation of a dental clinic, if dental personnel were available?

DR. McGRATH: No, some there is specific provision made, in others, just a makeshift provision, but I think in some of the newer, larger hospitals, there

municipal government here should take the initiative.

COMMISSIONER BAITZAN: Do you think, sir, that the problem has not been solved through insufficient measures for educating the public in relation to fluoridation?

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DR. McGRATH: No, some there is specific provision made, in others, that a makeshift provision, but I think in some of the newer, larger hospitals, there

is special provision for it, and I know the dentists do use the Cottage Hospitals as centres of operation.

COMMISSIONER STRACHAN: If dentists were available under the subsidization scheme, where would the priority be placed, in the Cottage Hospital or in a mobile clinic doing the outposts?

DR. McGRATH: We do not have a mobile dental clinic. It would be in the Cottage Hospital, or perhaps in the larger towns that do not have a Cottage Hospital, they might still have a dental clinic.

THE CHAIRMAN: Would a mobile clinic be an answer to the fact of the isolated areas in a Province such as Newfoundland?

DR. HANN: Experience has shown, I think, in recent years that while mobile clinics are effective to a limited extent, the loss of professional time in travel has to be considered, and I think the leaning now is to have a stationary clinic and have the patient go to the clinic, rather than have the clinic go to the patient.

COMMISSIONER STRACHAN: With the number of dentists employed by the Department of Health, how many schools -- I understand there are only two at the present time -- how many schools are they able to look after in this?

DR. McGRATH: We have full-time dentists in only two, but the whole dental profession has been co-operative in this work, and have done work for the Department. No, I couldn't say, but I would say this, that wherever there is a dentist, work is being done in the schools. I don't know of any case that I can think of

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COMMISSIONER STRACHAN: If dentists were available under the subsidization scheme, where would the priority be placed, in the Cottage Hospital or in a mobile clinic doing the outposts?

DR. McGRATH: We do not have a mobile dental clinic. It would be in the Cottage Hospital, or perhaps in the larger towns that do not have a Cottage Hospital, they might still have a dental clinic.

THE CHAIRMAN: Would a mobile clinic be an answer to the fact of the isolated areas in a Province such as Newfoundland?

DR. HANN: Experience has shown, I think, in recent years that mobile mobile clinics are effective to a limited extent, the loss of professional time in travel has to be considered, and I think the learning now is to have a stationary clinic and have the patient go to the clinic, rather than have the clinic go to the patient.

COMMISSIONER STRACHAN: With the number of dentists employed by the Department of Health, how many [illegible] time -- how many schools are they able to look after in [illegible]

DR. McGRATH: We have full-time dentists in only two, but the whole dental profession has been co-operative in this work, and have done work for the Department. No, I couldn't say, but I would say this, that wherever there is a dentist, work is being done in [illegible] schools. I don't know of any case that I can think o

offhand where there is a dentist in practice who is not doing some work for the children in this particular way.

COMMISSIONER STRACHAN: Is that more applicable to the outlying areas of St. John's?

DR. McGRATH: No, both the St. John's' dentists have been doing work too, and I am glad of this opportunity to thank them for it because I am quite sure this work is done from a sense of public responsibility, and not for remuneration, because remuneration is not high.

THE CHAIRMAN: You say work. What work?

DR. McGRATH: We are trying to get the group from five to seven years, we are advised that is the group that it should be done in, not exclusively, we have emergency cases, but that group, with the hope that if that group is treated for two years the parents will keep on the work afterwards. We think it is working out to some extent.

DR. HANN: As a matter of fact, in this brief we have suggested eventual expansion of this very program. We believe that efforts should be made at the pre-school, or early school level, and we hope that the best results of our work can be achieved that way.

THE CHAIRMAN: Are you aware of the experience in other areas, where there has been complete dental care at the elementary school age, that over a period of say 20 years, they have virtually worked themselves out of having anything to do?

DR. HANN: I realize that, but that is not the immediate problem.

THE CHAIRMAN: No, but that is merely pointing

is than more capable to the outlying areas of St. Louis?

DR. McGRATH: No, both the St. Louis dentists have been doing work too, and I am glad of this opportunity to thank them. I am convinced that this work is done from a sense of public responsibility, and not for remuneration, because remuneration is not high.

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DR. HANN: I realize that, but that is not the immediate problem.

THE CHAIRMAN: No, but what is merely pointing

up the importance of the work.

DR. HANN: Yes, that is a very desirable objective.

COMMISSIONER STRACHAN: I am struck, in looking over the list of dentists of Newfoundland, to find that the very large majority are graduates of the last 20, 21 years. Would you offer any general explanation why this has occurred? The Minister has suggested that subsidization has not been a factor because it has not been in effect long enough.

DR. BOWDEN: Mr. Chairman, I cannot pin down for you an exact reason as to what instigates a desire amongst these recent graduates to begin study in the first place. It is an accomplished fact that of the total number of dentists that are in the island today, as you say, most of them have graduated within recent years. Whether this has come as a result of their cognizance of the dental problem, or for some other reason, I am sure I cannot pin it down.

COMMISSIONER STRACHAN: I might add an appendix to that question. Have most of these graduates been natives of the Province?

DR. BOWDEN: Yes, most.

COMMISSIONER STRACHAN: In the best of your knowledge has there been a greater number of Provincial graduates, I mean graduates in dentistry from the Province, go to other parts of Canada, or have they returned?

DR. BOWDEN: In general terms.

COMMISSIONER FIRESTONE: If I may return for a moment to the question of fluoridation in paragraph 7,

DR. HANN: Yes, that is a very desirable objective.

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DR. BOWDEN: In general terms.

COMMISSIONER FITZPATRICK: If I may return for a moment to the question of fluoridation in paragraph 7,

page 4. Have municipal referenda been held whether to introduce fluoridation or not in the Province of Newfoundland?

DR. HANN: It has not.

COMMISSIONER FIRESTONE: Would your recommendation be that the Provincial Government require those communities which have a municipal system of government, that they hold such referenda?

DR. HANN: Our Association has never supported the view that a referendum determines with any degree of soundness the wisdom of fluoridation.

COMMISSIONER FIRESTONE: Then the answer to my question, if I understand you correctly, is no?

DR. HANN: The answer is no.

COMMISSIONER FIRESTONE: You would prefer the Provincial Government to order such fluoridation, rather than listening to what the people in the communities have to say; is that your view?

DR. HANN: Oh, I should qualify that, that we would prefer that the Provincial Government encourage municipalities, and the municipal governments themselves take the responsibility for implementing fluoridation.

COMMISSIONER FIRESTONE: But you would have no objections if this process of encouragement were done in the form of requesting municipalities to hold a referendum so that they can share the responsibility with the local citizens?

COMMISSIONER STRACHAN: I don't think it should be assumed that a municipality should have to hold a referendum. I think a council has the power to fluoridate

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COMMISSIONER STRACHAN: I don't think it

if it so desires.

DR. McGRATH: Our councils have that power, yes.

COMMISSIONER STRACHAN: But your government has not said that a plebiscite must be held?

COMMISSIONER McCUTCHEON: I take it that you feel that on the question of dental caries, that the view of the Dental Association is probably more valid than the view of the average voter?

DR. HANN: I wouldn't like to rule on the intelligence of the average voter.

COMMISSIONER McCUTCHEON: But your view is of more value?

DR. HANN: This is the only view we can take.

COMMISSIONER McCUTCHEON: Exactly as much as such things as vaccination and so forth.

COMMISSIONER FIRESTONE: But won't you agree that if these referenda were held, you would be more likely to achieve success, because under the present circumstances your results have been zero. It could be better, and it could not be worse.

DR. HANN: I think a thing of this kind resolves itself into purely a psychological and emotional situation, and the vote goes in favour of the stronger performers.

COMMISSIONER FIRESTONE: Do you think that the Dental Association has done enough to educate the public? After all, the response to such a vote is in part a matter of understanding of the problem. Would it

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not help to increase the education and the understanding of what is involved?

DR. HANN: I think that on every opportunity the Association endeavours to make known the advantages of fluoridation. It might very well be that the time is not ripe for this type of action yet.

COMMISSIONER FIRESTONE: Do you feel you could do more?

DR. HANN: I think it would be very difficult for the general practitioner to go beyond the extent that he has already gone. I think that the further role would have to be carried out by people trained in public health.

COMMISSIONER FIRESTONE: May I now turn to your top paragraph on page 6, where you recommend certain tax concessions, especially on equipment purchases. Do you have in mind, sir, for example the permission to charge double depreciation rate for new equipment purchased, or have you any other specific proposals in mind, or if you are not prepared to answer this question at this moment, would you be prepared to consider this among your colleagues, and let us have your views as to the specific things that can be done in the field of taxation concessions?

DR. HANN: I would just like to explain that we did have in mind here the exemption from possibly sales tax, and as you mentioned, accelerated depreciation, but if the view could be more clearly put, I would be very happy to put in a supplementary brief.

COMMISSIONER FIRESTONE: If you are putting

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COMMISSIONER FIRESTONE: If you are putting

in a supplementary brief, could you also spell out your recommendation 5 contained in your summary, establishment of financial incentives for rural practice. What kind of incentives, and how would they work, and where would the money come from to pay for them? And also what you mean under VI, the scholarship and student loan fund. Can you give us details, amounts, numbers, etc., over a period of 5 years?

DR. HANN: I could do that sir. I could make an observation here. In speaking of establishing a scholarship fund I would like to say that the profession heartily endorses the subsidization plan already in effect by the Provincial Government. The prime purposes of course for this subsidization are to attract men back into areas where they probably would not otherwise locate. There is the other feeling that there should be another alternative for men to obtain professional education. There are men who believe in investing in their own education, and this would enable them to accept opportunities on a competitive basis. Therefore, we feel the establishment of a student loan fund, either partly established by the profession or by the Government, would provide an avenue of assistance.

COMMISSIONER FIRESTONE: Can I take it from your answer, sir, that you will be obtaining supplementary information on the last two points as well?

DR. HANN: Yes.

DR. McGRATH: May I make a point here, with regard to section 10. "---dentists might be expected to locate in rural areas if the financial incentives were attractive. Such incentives might include - the provision

under VI, the scholarship and student loan fund. Can you

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DR. McLAAIN: May I make a point here, with regard to section 10. "---dentists might be expected to attractive. Such incentives might include - the provision

of dental equipment (ownership retained by Government) located in the Cottage Hospital or medical clinic".

That is actually being done now. Any dentist who comes out to practise in an outport under Government aegis is given his equipment on loan, for which he pays nothing, and we also pay the rent of his quarters, so that is actually being done.

THE CHAIRMAN: Thank you very much, gentlemen, for this presentation, which has been most helpful.

We will now adjourn until 10 o'clock tomorrow morning.

THE SECRETARY: A document was left with me by Dr. Baird. It is observations on the Newfoundland Cottage Hospital Service, and I will put it in as Exhibit 23A.

--- EXHIBIT NO. 23A: Document containing observations on the Newfoundland Cottage Hospital Service.

--- Whereupon the hearing adjourned until 10 a.m., Friday, November 3rd, 1961.

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ROYAL COMMISSION ON HEALTH SERVICES

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HELD AT

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COMMISSION MEMBERS:

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Miss ALICE GIRARD, R.N.

Mr. DAVID M. BALTZAN

Prof. O.J. FIRESTONE

Mr. M. WALLACE McCUTCHEON, Q.C.

Dr. C.L. STRACHAN

Dr. ARTHUR F. VAN WARD

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MEDICAL CONSULTANT:

Dr. PIERRE JOBIN

DIRECTOR OF RESEARCH:

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Maj. N. LAFRANCE

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St. John's, Newfoundland,
Friday,
November 3rd, 1961.

---On resuming at 10:00 a.m.

THE CHAIRMAN: The submission on behalf of the Newfoundland Federation of Labour, and that will be known as Exhibit No. 25.

---EXHIBIT NO. 25: Submission of the Newfoundland Federation of Labour.

THE CHAIRMAN: Are you ready, gentlemen?

MR. GILLIES: We have got a summary here, Mr. Chairman, that has not been distributed to the Commission. We have nine points here that we feel are the major points in our brief.

SUBMISSION OF

NEWFOUNDLAND FEDERATION OF LABOUR

APPEARANCES: Mr. J. W. Gillies, Secretary-Treasurer

Mr. L. Dobbin, Vice-President

Mr. H. Horwod

MR. GILLIES:

1. We are opposed to any health plan which divides Canada into regions or classes. We believe that health services ought to be equally available to all, irrespective of their financial status or geographical location.
2. The historical trend is toward a centralized health service administered by the state, as already set up in 54 countries. Canada's health needs could best be

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2. The [illegible]torical trend is toward a centralized health service administered by the state, as already set up in 34 countries. Canada's health needs could best be

served by a national public health programme, comprehensive in scope, responsible for the health needs of the entire nation, and not in the realm of insurance alone, but also for the provision of services, institutions and personnel.

3. Newfoundland is far behind even the poorest of the other provinces in health services, and cannot hope through the agency of its provincial government to provide even the minimum needs of our people. We are lacking in doctors, dentists, nurses and institutions.

4. The cottage hospital plan served a very useful purpose in its time but it is now outmoded, and should not be extended. The cottage hospitals are not equipped for modern treatment and surgery. Newfoundland needs small general hospitals in all the main centres of the province, within reasonable travelling distance of the population. The air ambulance service is useful, but depends upon too many uncertain factors to make it a substitute for hospital services on the spot.

5. Newfoundland is actuely in need of a number of specialist institutions; an orthopaedic hospital for the treatment of congenital and other long-term bone diseases and injuries; an institute of phsiotherapy for crippled children; a public nursing home for the aged; a custodial institution for the criminally psychopathic, the congenitally incurable, the degenerate psychopaths not expected to respond to treatment. No such specialist institutions have been built in Newfoundland since Confederation.

6. The population of the province is increasing more

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Newfoundland is far behind even the poorest of the other provinces in health services, and cannot hope through the agency of its provincial government to provide even the minimum needs of our people. We are lacking in doctors, dentists, nurses and institutions. The cottage hospital plan served a very useful purpose in its time but it is now outmoded, and should not be extended. The cottage hospitals are not equipped for modern treatment and surgery. Newfoundland needs small general hospitals in all the main centres of the province, within reasonable travelling distance of the population. The air ambulance service is useful, but depends upon too many uncertain factors to make it a substitute for hospital services on the spot.

Newfoundland is sorely in need of a number of specialist institutions; an orthopaedic hospital for the treatment of congenital and other long-term bone diseases and injuries; an institute of physiotherapy for crippled children; a public nursing home for the aged; a custodial institution for the criminally psychopathic, the congenitally incurable, the degenerate psychopathic not expected to respond to treatment. No such specialist institutions have been built in Newfoundland [illegible].

The population of the province is increasing more

rapidly than the provincial government is able to provide health services, especially specialist services of one kind and another. Moreover, the government finds it more and more difficult to secure qualified personnel to staff its institutions and to serve in the public health services.

7. The record of health services in Newfoundland indicates that the only hope of the province for a modern health service lies in the provision of National Health Insurance by the Federal Government. But "insurance" alone would do little to fill the greatest need. Only National Health Insurance which included an undertaking by a central Department of Health in Ottawa to provide needed services, institutions and staff, would fill the need in Newfoundland.

8. A comprehensive national health service, fully pre-paid out of taxes and equally available to all citizens of Canada, could be financed on an operating budget of a billion dollars a year -- no more than is now spent on services which often result in wasteful duplication while depriving certain "have-not" citizens of essentials.

9. The total costs of health care in Canada, now financed out of private pockets, through insurance, through municipal, provincial and federal governments, and out of charity and unpaid labour in some cases, amount, in toto, to a larger figure, measured against the gross national product, than do the costs of health care in Great Britain, where health services are all-inclusive and financed by the state through central taxation.

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The difference between the two countries is four-tenths of one percent, which amounts, in Canada's case, to something in excess of one hundred million dollars a year.

Mr. Chairman and Members of the Royal Commission:

This brief is submitted on behalf of the Newfoundland Federation of Labour, a provincial body representing some 21,000 organized workers throughout the province; together with their families, about a fifth of the population of Newfoundland. This Federation is concerned with legislative matters which affect the workers of Newfoundland in particular; to a much less extent with wider national and international issues which are the legitimate concern of the Canadian Labour Congress. Since Health Services in Newfoundland present special problems and have a history of development quite different from that of Mainland Canada, we feel, however, that we ought to call your attention to the special needs of this area, and to the principles which we believe ought to govern any plan by which those needs are to be met.

First, let us state that we regard Health Services as a national rather than a regional problem. The historic development of Health Services leads toward centralized national control with equal distribution to all citizens. Health was at first the sole responsibility of the individual family. Later, as society evolved, it became the concern of voluntary organizations, then of cities and towns, then of provinces and states. We have to-day the vestiges of all those systems still existing side by side, so that the head of the family is still

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1 responsible for the major expenses involved in the health
2 care of his dependents; voluntary organizations continue
3 to carry on nursing services; churches and charitable
4 societies continue to operate hospitals; cities and towns
5 and provinces continue to implement their own public
6 health schemes; and lastly the Federal Government concerns
7 itself with the health of the nation. We submit that a
8 single, co-ordinated, public health service, directed by
9 the state on a national scale, is the evenutal goal toward
10 which Canada should aim, and that the historical development,
11 both here and in other parts of the world, is tending in
12 this direction.

13 We will therefore state briefly the
14 principles upon which we believe such a national Health
15 Service should be based, and then, since we recognize that
16 the implementation of such a national plan is necessarily
17 a very long-term project, we shall deal with the special
18 situation in Newfoundland.

19 Canada is one of the few countries in the
20 world which still does not extend Health Services to its
21 citizens as a matter of right. In this country Health
22 Care is still largely a matter of wealth, modified by the
23 luck of the environment -- that is, by the services avail-
24 able in the region where the citizen happens to live.
25 Fifty-four countries ranging in size from China to India
26 down to Luxembourg, have comprehensive, pre-paid public
27 health services. Virtually all the "middle powers" which
28 compare with Canada -- countries such as Sweden, Australia,
29 Turkey, Yugoslavia, Spain, Poland and Italy -- extend to
30 their citizens a programme of comprehensive medical care

and provinces continue to implement their own public health schemes; and lastly the Federal Government concerns itself with the health of the nation. We submit that a single, co-ordinated, public health service, directed by the state on a national scale, is the eventual goal towards which Canada should aim, and that the historical development both here and in other parts of the world, is tending in this direction.

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1 financed out of taxation. Moreover, this is done without
2 respect to the political complexion of the countries
3 concerned. It is done in communist countries such as the
4 Soviet Union, in fascist countries such as Spain, in a
5 moderate socialist country such as Norway, and in con-
6 servative capitalist countries such as Western Germany.
7 We point this out in order to dispose of the idea that a
8 national health service financed out of taxation is some
9 sort of wild radical dream, as some elements in Canada
10 would have us believe. It is, in fact, a most conservative
11 and highly respectable proposition which has no political
12 colour whatever.
13 Basic Principles for National Health Service:
14 Canada's Health Services, then, should be
15 centred in a national public health programme, compre-
16 hensive in scope, extended on an equal basis to all
17 citizens throughout the country, that is, available to all
18 regardless of means, and financed out of general taxation.
19 Moreover, this national public health programme should
20 insure health services of the highest quality, and to this
21 end should include an advisory council representing
22 Government, Health Administration, Medical Science and
23 the public. This public health programme should be
24 responsible not only for financing medical services, but
25 for providing and equalizing medical services, preventive
26 health care and health education throughout the country.
27 The principle of extending health services
28 on an equal basis to all citizens regardless of means is
29 not one which we should have to argue. It has been
30 recognized and endorsed by most religious bodies; repeatedly

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Soviet Union, in fascist countries such as Spain, in a moderate socialist country such as Norway, and in conservative capitalist countries such as Western Germany. We point this out in order to dispose of the idea that a national health service financed out of taxation is some

would have us believe. It is, in fact, a most conservative and highly respectable proposition which has no political

Canada's Health Services, then, should be centred in a national public health programme, comprehensive in scope, extended on an equal basis to all citizens throughout the country, that is, available to all regardless of means, and financed out of general taxation. Moreover, this national public health programme should insure health services of the highest quality, and to this end should include an advisory council representing Government, Health Administration, Medical Science and the public. This public health programme should be responsible not only for financing medical services, but for providing and equalizing medical services, preventive health care and health education throughout the country.

The principle of extending health services on an equal basis to all citizens regardless of means is not one which we should have to argue. It has been

by the United Church of Canada, for example, its national conferences, and very recently and pointedly in the major encyclical letter, "Mater et Magister" issued by Pope John XXIII. It was even recognized by the Government of Canada 16 years ago in its proposals to the Dominion-Provincial Conference of 1945, when "first stage" health insurance was proposed to include hospitalization, doctors' bills, and visiting nursing services, with other medical services to be added in later stages. Unfortunately, though Governments have come and gone, and six general elections have passed into history, we are still far from achieving this "first stage". One can only assume that when the Canadian Government talks of the introduction of major public services it is thinking in terms of generations, or perhaps even of centuries.

We will not go into details of various plans proposed under the name of health insurance or national health schemes. We will state only that we are opposed to any plan which calls for the participation of private insurance companies, any form of so-called "co-insurance", which is merely a euphamism for making the private citizen bear certain costs out of his private means, or any system of segregating the population into groups for purposes of health services. The only health plan which we will support in full is one which is national in origin and administration, all-inclusive in scope, and fully financed out of taxes of general application. Such a plan could be financed on an operating budget of the order of a billion dollars a year, rather less at present, rather more, ten years hence. (This

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estimate, originally made by rough-totalling present health costs across Canada has since been confirmed by comparing the percentage of health costs of the gross national product in countries with comprehensive plans and prorating Canada.

Newfoundland's special health problems stem from the historical context and from the distribution of the population in many hundreds of small and far-scattered towns sometimes without communications except by air or sea.

The Doctor: Patient ratio:

Historically, this province was a British Crown Colony, and then an independent member of the British Commonwealth, coming very late into the Canadian Confederation. The long record of independent development, underwritten for the first three centuries entirely by the fisheries, and for the fourth century only to a limited extent by forestry and mining, was accompanied by a very low standard of living and a correspondingly low standard of public serives. The first general hospital in Newfoundland was not established until the second quarter of the 19th century, through the influence of Dr. William Carson, and on the pretext of military necessity. The extent to which medical services in Newfoundland were inferior to those in the rest of Canada at the date of Confederation (1949) may be judged from the fact that the ratio of doctors to the population was less than a third of that for Canada as a whole, despite the fact that the Newfoundland population was far more dispersed and more difficult to serve than average populations across the

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country.

In 1959, after ten years of vigorous effort by the provincial Government to increase the volume of medical services, the ratio of doctors to the population in Newfoundland was still 1:2190 -- which, in theory meant that the average doctor had to serve over 2,000 people, though in fact the distribution of doctors was so uneven that some of the more remote areas had only one doctor for 15,000. This compared to one doctor for 938 in Canada, and one for 767 in British Columbia, the province with the lowest doctor:patient ratio.

We must emphasize again that the deficiency is even greater than the figures would indicate, since the medical services, and the general practitioners, are concentrated in a few large centres, while whole regions (for example, large areas of the southwest coast, northeast coast and Labrador) are entirely without domestic medical services, relying on air ambulance to handle emergency cases, and suffering frequent mortalities when air services are grounded or a little late.

Cottage Hospitals:

Down to 1932 Newfoundland's public health services were very meager. The only public hospitals were in St. John's, and all health services in the coastal towns were carried on by scattered doctors and nurses operating without the benefit of any institutional facilities. The Commission of Government which came into office on the suspension of Newfoundland's Dominion Constitution in that year initiated the Cottage Hospital scheme, which was a long step toward the provision of

[illegible]

[illegible]

[illegible]

health services for the more populous parts of the coastal population.

The Cottage Hospital Service, in brief, consisted of small hospitals with very limited facilities, available to the local population on a pre-paid plan -- in effect, a very economical yearly fee paid by the head of each household on behalf of all his dependents. Some of the cottage hospitals had nurses only, no resident doctors and even those with resident doctors were not equipped for major surgery, or even for many of the medical procedures which are considered routine in larger institutions. It was, and still is, necessary to airlift emergency cases from cottage hospital areas to hospitals in St. John's or Corner Brook for treatment or radical surgery. Nevertheless, even with the comparatively crude equipment available, cottage hospital staffs have, on occasion, undertaken major surgery when airlifts were not possible. The Grenfell hospitals in Newfoundland and Labrador, though technically private institutions, are government-supported, and in all important respects are cottage hospitlas like those owned by the Government of Newfoundland. They, too, undertake from time to time in emergencies techniques which ought not be attempted except in a modern and fully-equipped institution. For example, brain surgery has been performed at the Grenfell Hospital in St. Anthony, and many types of radical surgery undertaken at the little hospitals in Cartwright and Northwest River, at periods when it was difficult or impossible to move patients to larger centres.

Dental Health:

Except for the striking example of St. Lawrence,

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which has a natural water supply with a high content of calcium fluoride and other minerals, Newfoundland's dental health is notoriously poor, and dental health services totally lacking in most parts of the province. In fact, for the great majority of Newfoundlanders the only form of dental treatment consists of extractions, usually performed not by dentists but by general practitioners or even registered nurses. We think this point deserves some elaboration.

The general practitioner and the registered nurse are both able to pull teeth, but lack not only the training, but also the equipment to do anything else about dental caries. Unfortunately, hundreds of thousands of Newfoundlanders never see a dentist. Many of them see only a doctor, or a nurse, during a tour, by boat, of a Grenfell or public health team visiting the settlements along a certain stretch of coastline. Those suffering from acute dental disease then flock to the doctor or nurse, seeking treatment, and receive the only kind of treatment available; extractions. Others, not in the acute stage of suffering, put up with a dozen or more decayed teeth for months and years and even decades, perhaps pulling the stumps by the string-and-door technique when decay has advanced to its final stages. This, of course, undermines the entire state of physical health of the person concerned. We are not over-stating the case. If anything, we are understating it. Newfoundland has a dental problem of absolutely major proportions, and no promise of the personnel to cope with it.

This year there are exactly 42 dentists in

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Newfoundland -- one for every thousand square miles of the island -- one for every three and a half thousand square miles if we include Labrador -- one for every ten thousand people. Even at that, our dental force has increased by one hundred percent in the past ten years.

But again, the situation is worse than mere figures would indicate, for if you take the populations living outside of St. John's and Corner Brooke, where nearly all dentists are concentrated, you find that we have only one dentist for every 30,859 people in the outports and small industrial centres. The only other province which approaches our shortage of dentists is NewBrunswick, where the per capita supply of dentists is twice as large as ours.

Nursing Services inadequate:

The same deficiency, in only lesser degree, is found in the supply of Registered Nurses. In Canada as a whole there is one Registered Nurse for every 260 of the population; in Newfoundland, one for every 508. These deficiencies would be even more severe except for the policy of the Newfoundland Government of recruiting doctors, dentists and nurses in Europe, and bringing them here to enter the public health services. This policy, begun by Commission of Government, has been continued since Confederation. However, since the introduction of the National Health Service in Great Britain, with the corresponding increase in living standards and improvement in working conditions for doctors, dentists and nurses, it has become increasingly difficultto induce medical personnel to emigrate. During several recent recruitment

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Nursing Services Inadequate:

The same deficiency, in only lesser degree, is found in the supply of Registered Nurses. In Canada as a whole there is one Registered Nurse for every 560 of the population; in Newfoundland, one for every 906. These deficiencies would be even more severe except for the policy of the Newfoundland Government of recruiting doctors, dentists and nurses in Europe, and bringing them here to enter the public health services. This policy, begun by Commission of Government, has been continued since Confederation. However, since the introduction of the National Health Service in Great Britain, with the corresponding increase in living standards and improvement

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drives by the Newfoundland Government, not a single doctor or nurse has been secured, and it appears that in future we are going to have to rely on medical personnel recruited in Canada. It seems unlikely that the needs of this province for medical personnel can be filled without help from a national health plan which includes the supply of personnel to the various parts of the nation.

Immediate Hospital Needs:

The cottage hospital plan, and the system of visiting doctors and nurses travelling by boat and by dog team, served admirably in their time, but they are not adequate to meet the present needs of Newfoundland, much less the needs which will arise in the immediate and near future.

The first and most obvious need is for fully-equipped hospitals and dental clinics staffed by qualified personnel in all the large centres of the province, with specialists and laboratory equipment in regional centres.

Taking the province geographically, coast by coast, we would say that the minimum needs of the people could only be met by hospitals in the following places: St. John's, Bell Island, Carbonear, Clarenville, Bonavista, Gander, Wesleyville, Carmanville, Lewisporte, Fogo, Twillingate, Grand Falls, Buchans, Springdale, Baie Verte, St. Anthony, Cartwright, Northwest River or Goose Bay, Nain, Port Saunders, Bonne Bay, Corner Brook, Stephenville, Port aux Basques, Burgeo, St. Albans, Bay L'Argent, Grand Bank, Burin or Marystown, Placentia, St. Josephs, Trepassey. Even with those 32 hospitals, equipped to handle any sort of

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case except that demanding specialist work, the geography of the province is such that many people might still be beyond the reach of medical help in an emergency, but such a hospital system would bring medical services within the reach of all the people of Newfoundland in all normal circumstances. Each of the hospitals suggested should, of course, have a dental clinic attached. There are at present just enough dentists in Newfoundland to staff such a chain of clinics, with none left over for practise in the larger centres where they are now concentrated. At least another 50 dentists would be needed immediately for practise in the cities and industrial towns.

Some of the towns mentioned already have cottage hospitals, and there are a few other cottage hospitals which, due to the changing human geography of the province, are located at the wrong places, though they might have been the right places in the days where virtually all transport was by sea. The cottage hospitals are, however, totally inadequate to meet the present needs of the province, and no further extention of the cottage hospital system should be envisaged.

In addition to the general hospitals suggested above, the following places should be regarded as regional centres, and equipped with laboratory facilities and specialists:

St. John's, Clarenville, Gander, Twillingate, St. Anthony, Northwest River or Goose Bay, Corner Brook, Port aux Basques, Grand Bank -- nine regional centres. These centres should have hospitals capable of providing a full range of surgical diagnostic, medical and

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Port aux Basques, Grand Bank -- nine regional centres. These centres should have hospitals capable of providing a full range of surgical diagnostic, medical and

radiological techniques.

Such a hospital system, considered on a per capita basis only, would be suprerior to that now existing in any province in Canada, but considered on the basis of distances and of isolation, would be barely sufficient to meet the needs of the people.

Special Types of Hospitals:

In addition to the general hospital needs so far outlined, there is acute need for special types of hospitals for treating long-term and chronic diseases. These could well be located at only one or two centres in the province -- at St. John's and Corner Brook for example -- since they are not the sort of institution to which it is necessary to rush a patient in order to save his life.

Tuberculosis, once the most widespread and dangerous disease in Newfoundland, has been brough largely under control, and facilities for its treatment are adequate. The same cannot be said of facilities for the treatment of mental and nervous diseases. Not only are facilities inadequate to meet the need for treatment of acute cases, but it is impossible, at present, to segregate long-term degenerate cases, the senile, the congenitally inadequate, and criminal psychopaths, from those for whom there is prognosis of rapid improvement under treatment. Obviously separate institutions are needed -- one for treatment of mental and nervous diseases in those who are expected to respond, and another for long-term custodial care of those who are not expected to respond.

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Another, and wholly separate, institution is needed for the nursing care of the aged and infirm.

The present intitution at St. John's is not only a disgrace to Newfoundland, but a blot on the decency of the Canadian nation and an insult to humanity. The aged and infirm who are not able to afford the private nursing homes are herded into this pest hole, which has been condemned as a fire trap by city authorities, and are there treated like cattle, without medical attention, without decent food, without adequate recreation, or even the elementary comforts. Acute disease, senile insanity, and mere physical disability are there herded together in an atmosphere of general horror and degradation. Conditions are so bad that official requests by the leaders of the labour movement to inspect the institution have been ignored, and a committee of the St. John's Trades and Labour Council which applied at the office of the infirmary for a guided tour of the institution was forbidden by the Government to proceed further. A subsequent written request for permission to enter the building on a planned and guided tour was not answered. Individual labour leaders who have secured entrance as private visitors have, however, reported that the home for the aged and infirm is utterly below any acceptable standard for decency for any public institution. Even as a prison it would be condemned. The Newfoundland Government, eight years ago, promised to build a new institution for the nursing care of the aged and infirm, but has so far done nothing about it. The senile aged continue to be housed in a wooden fire trap which was built well over a hundred years ago, and has never been equipped with any modern facilities.

A fully-equipped hospital for the rehabilitation

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A fully-equipped hospital for the rehabilitation

of children suffering from congenital defects and from the trauma of crippling diseases is also a crying need. The Orthopaedic Hospital at St. John's is a converted barracks, erected over 20 years ago as a purely temporary building for war-time use. It has no resident surgeon or physician. It is inadequately staffed and inadequately equipped. Patients of all ages from infancy to advanced old age are crowded together. There is no equipment for radiology or surgery in the building, and it is unclean.

In addition to the Orthopaedic Hospital, the Sunshine Camp, a private institution, does rehabilitation work, specializing in physiotherapy for children who can be helped by special exercises and special teaching techniques. This work should be taken over either by a separate public institution, or by a wing of the new orthopaedic hospital. The waiting list for child physiotherapy in Newfoundland is enormous, and case-finding work is very far from complete.

The failure of the Government of Newfoundland to provide the institutions needed for the health care of the population is underlined by the fact that no specialist institutions have been built in the province since Confederation, with the exception of the completion of work already undertaken by Commission of Government. Facilities for the treatment of mental disease, diseases of muscles and bones, for the care of the aged, and for the rehabilitation of crippled children, remain exactly what they were before Confederation, except that a new wing, already begun by Commission Government, was completed at the Hospital for Mental and Nervous Diseases since Newfoundland

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became a province of Canada.

Population outstrips Health Services:

The population of the province is increasing rapidly -- much more rapidly than even the adequate medical services which the Provincial Government attempts to provide. As the population increases yet further, the existing facilities for specialist treatment, created to serve a population half the size of the present one, and housed in buildings which, in some cases, were not designed for hospital use at all, become more and more glaringly inadequate.

Newfoundland, then, is deficient in all branches of health services, but particularly in general hospitals which can be reached by the people living in the outports, in specialist services of all kinds, including rehabilitation work, care of the aged and treatment of crippled children, and in dental services throughout the province with the exception of St. John's. The Government of the province has shown itself completely incapable of coping with the problem, and the only hope which the province has for even a modicum of modern health services is that a national health plan will be instituted by the Federal Government.

We must point out that mere health insurance with emphasis on the "insurance" would not begin to fill the need. True, it would relieve the burden of sudden bankruptcy which now decends upon the head of a household one member of which is stricken by illness requiring prolonged and expensive treatment. To that extent national health insurance of a comprehensive kind would be a good

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thing and would receive our support. But such an insurance scheme would not meet the special regional problems which we face here; problems which have their roots in our history of poverty, in our geography of isolation, and in the failure of our Government to provide the basic institutions needed for treatment. To meet our needs a national health plan would have to go much further than insurance. It would have to be responsible for the provision of hospitals, clinics, and staff, sufficient to provide minimum medical care for all our people.

Health Education:

We have said nothing, so far, on the subject of health education. We have, in fact, been subjected to a fairly constant stream of health propaganda in the form of broadcast and printed slogans, widely distributed throughout the province, especially in the 12 years since Confederation. Much of this propaganda, useful as it may be in large urban centres where health services are available, is the height of irony in rural Newfoundland.

"Brush your teeth three times a day and see your dentist twice a year!" proclaims the poster on the school-room wall. Most of the children in the room have a dozen or more cavities which cannot be treated because the nearest dentist is 150 miles away, and can be reached only by chartered plane.

"Fight cancer with a checkup and a cheque!" the radio commands the people of our most remote settlements. Many of them have some of the symptoms described in the publicity put out by the Cancer Society. But the "checkup" which is demanded of them can only be performed

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at a surgery or hospital which is five days away by coastal boat. If they are lucky they may see a travelling general practitioner once or twice a year. If they mention suspected cancer symptoms, he is likely to tell them to go home and forget about them, that they are imagining things. He is not equipped either to diagnose or to treat cancer, and he knows that the chances are better than 50-50 that the symptoms in question are harmless, so the majority of his patients return home from the travelling boat or the temporary clinic in the school house to live and forget their symptoms, while the minority -- a large minortiy -- go home to grow gradually worse until the symptoms can no longer be either ignored or successfully treated.

"Prize your eyes!" commands the Canadian National Institute for the Blind, warning of the dangers of Glaucoma and other degenerative eye troubles which may result in permanent blindness if undetected until too late. Empty advice, this, to people on the coast of Labrador, or at the head of Bay d'Espoir, where no eye specialist has ever been known to pause, even in transit, and from which anyone needing an eye examination by a competent physician capable of diagnosing anything more serious than astigmatism would have to travel to St. John's which seems, in either case, almost half a world away.

Even in the branch of nutrition, which has been the subject of considerable effort by those interested in preventive medicine for many years past, the special problems of Newfoundland make irony of much that is passed along to our people with the best of intentions by those

imagining things. He is not equipped either to diagnose or to treat cancer, and he knows that the chances are better than 50-50 that the symptoms in question are harmless, so the majority of his patients return home from the travelling post or the temporary clinic in the school-

minority -- a large minority -- go home to grow gradually worse until the symptoms can no longer be either ignored or successfully treated.

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Even in the branch of nutrition, which has

who never travel beyond the reach of the supermarket and the frozen food counter. What use is it to counsel people to eat fresh green, leafy vegetables at least once a day, when they couldn't purchase a fresh, green leafy vegetable even with their very life's blood for months at a time -- sometimes for as much as six months at a stretch?

The point we wish to make is not to ridicule the subject of health education, but to underline, emphasize and print in bold face the fact that health education designed for Toronto is often, indeed usually, worthless or even worse than worthless in this part of the country. Health education in Newfoundland must be designed for local conditions. Instead of counselling the people to eat the things which cannot be bought with love or money, they should be instructed how to choose the equally healthful foods which can be bought in their local stores. Instead of urging school children to visit dentists twice yearly at a cost of $150 or so per trip, it would be much more effective to teach their parents the art of social agitation; how to raise such a public uproar over the lack of health services that dentists would, in fact, be provided by the people who are elected and paid by the people to provide such essential services.

Regional differences will persist for a long time, and hence the need to adapt particular aspects of health services to one region or another. But this does not weaken in the least our basic argument that the national health plan cannot be conducted on a regional basis or left to the administration of regional authorities. The regional differences show only the need for flexibility

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and adaptability in such a national health plan -- the need for its comprehensiveness to comprehend the diversities of the Canadian nation as well as the diversities of need between one individual and the next.

The Constitutions "Problem".

We are fully aware of the fact that the implementation of a public health plan at the Federal level, Federally administered, without the agency of the provincial governments, would require amendment of the Canadian constitution. Such amendment should not be too difficult to secure, since the consent of most provincial governments would be merely a matter of form. True, Federal funds spent through the agency of the provinces are a tempting source of political advantage to those who happen to be in power in the provinces. But on the other hand the burden of adequate health services is increasingly great, particularly since administration of ten separate health services by ten separate provincial governments causes a mass of administrative duplication. There are also in Canada some 30 urban departments of health or health authorities, creating still further duplication. The experience of the British National Health Service indicates that with the consolidation of health services at the national level, and the elimination of such duplication, important improvements in the level of health services can be achieved without a corresponding increase in costs. Indeed during the first eight years of the National Health Service of Britain, while the various branches of the service were greatly expanded and improved, there was a slight and fluctuating, but nonetheless constant, decline

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Service in Britain, while the various branches of the

in the cost of the service as a percentage of the gross national product. The decline in eight years was from 3.52 to 3.23 -- in other words, eight percent, or an average of one percent per annum.

It may also be worth mentioning that the costs of health care in Canada, where health services are wastefully duplicated and at the same time inadequate, are higher, measured against the gross national product, than they are in Great Britain, where they are reasonably adequate, and where wasteful duplication has been eliminated. The differnce is about four-tenths of one percent of the total national expenditure, which may seem trifling until we remember that, in Canada's case, this amounts, in round figures, to something more than a hundred million dollars a year.

(Signed)

President: Esau Thoms

Secty-Treas: W. J. Gillies

Vice-Presidents: Laurence Dobbin
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Calvine Normore
James Mullett

THE CHAIRMAN: Do you wish to amplify your summary with any observations?

MR. GILLES: Well, I think Mr. Chairman the brief will do that, unless Mr. Horwod has something to say.

MR. HORWOD: Well, let me say this, Mr. Chairman: The brief was rather carefully thought out, and I thought written in as terse a manner as could reasonably be expected. We go into what we believe ought to be the national health service of Canada. In it we

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MR. HORWOD: Well, let me say this, Mr. Chairman: The brief was rather carefully thought out, reasonably be expected. We go into what we believe ought be the national health service of Canada. In it we

present what we think are sound arguments as to why Canada needs a health service. We do not ignore the constitutional problem involved, and it is impossible to summarize a brief of this sort, which runs to about ten pages, in the way we have attempted to do here. All we could do was simply touch on some of the major points without going into the arguments in support of those points.

THE CHAIRMAN: Mr. Horwod, your brief recognizes the constitutional implication of the division of legislative powers between the Federal Government and Provincial Governments, and your recommendation is, as you say, that you oppose anything on a regional basis and that only a centralized programme operated by the Federal Government, would, in your judgment, be satisfactory. Do you appreciate that would necessarily involve a constitutional amendment?

MR. HORWOD: Oh yes, indeed we do, but the constitution of Canada also forbade the Federal Government to collect income tax, but it didn't stop the collection of that by the Federal Government when the second World War broke out, and the tax fields were quickly -- what is the word -- "rented" by the provinces to the government. It is the case, in our opinion, of an obvious national need. Canada started as a group of separate colonies ---

THE CHAIRMAN: Mr. Horwod, I think you will have to accept that we do have some knowledge of the historical background of the organization of Canada.

MR. HORWOD: Quite so.

THE CHAIRMAN: And your statement that the constitution forbade the imposition of income tax -- I

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MR. HORWOD: Quite so.

THE CHAIRMAN: And your statement that the constitution forbade the imposition of income tax -- I

think a constitutional lawyer would tell you that is not a correct legal position.

MR. HORWOD: I thought of that, actually, as I said it. It was a matter of duplication.

THE CHAIRMAN: Because there has never been, as far as I know, any serious suggestion that the right to impose taxes was denied to the Federal Government.

MR. HORWOD: Of course, the right to provide health services is not denied either.

THE CHAIRMAN: My question to you -- and it is not a matter of argument; I am trying to get a viewpoint -- if we have to recognize that before you can have a plan operated nationally that it would need a constitutional amendment, is it your view that the attempt to put in any kind of plan must await that constitutional amendment?

MR. HORWOD:: Well, it is coming, apparently, step by step. The hospitalization insurance is already operated by the Federal Government.

THE CHAIRMAN: Don't you recognize the hospitalization plan is operated by the provinces?

MR. HORWOD: Oh, yes, it is operated by the provinces and financed by taxation.

THE CHAIRMAN: Financed in part.

MR. HORWOD: Yes. We discuss the question of using the provinces as agencies of the federal government in a national health plan. We recognize the fact that short circuiting this thing and not using the provinces as an agency will constitute certain constitutional difficulties. We would certainly rather see a

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MR. HORWOOD: Yes, we discuss the question of using the provinces as agencies of the federal government in a national health plan. We recognize the fact that she is attempting this thing and not using the

national health plan operated through the agency of the provinces than none at all, but we feel that a considerable amount of duplication and so on, and wasteful expenditure would be eliminated if you could eliminate the ten departments of health and so on, and have one centralized agency.

Our main argument in this connection concerns the supply of services. If the province is responsible, if the province or area or city is responsible for supplying insitutions and securing personnel, then the problem will always remain that the poorer sections of Canada, such as Newfoundland, are going to find it difficult to have health services on a par with the richer sections of Canada such as Ontario.

THE CHAIRMAN: I want to remain for the moment on the subject that I raised, in connection with any possible plan that this Commission could conceivably recommend, and to revert to the language used here yesterday of something that is practical and realistic, and that is why I necessarily raise this question of the provincial rights in terms of education, insofar as the operation of educational institutions, universities, nursing are concerned -- that kind of thing -- in the face of your recommendation that everything be done by the national government.

MR. HORWOD: We recognize the fact, of course, Mr. Chairman, that a constitutional amendment of this sort could not be initiated without the consent of the provinces concerned. We mention this in the brief at page 13, and we mention also that the provision of health

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MR. GORWOD: We recognize the fact, of course, Mr. Chairman, that a constitutional amendment of this sort could not be initiated without the consent of the provinces concerned. We mention that in the brief [illegible] 13, and we mention also that the provision of health

services is a very heavy burden on the provinces and an increasingly great burden on the provinces, and that, in our opinion -- and, of course, other people may hold different opinions -- but, in our opinion, the consent of the provincial governments because of this cost factor and the heavy load of carrying health services should not be too difficult to obtain. That is something that would have to be explored. We cannot simply state that the constitutional amendment would be accepted throughout Canada.

THE CHAIRMAN: Do you as a group appreciate that under the present constitutional arrangement all the federal government can do is provide money?

MR. HORWOD: Yes, we realize that.

THE CHAIRMAN: The services must be handled by the province, and therefore the services may not be identical in each province.

MR. HORWOD: However, I might state, Mr. Chairman, that not all of our recommendations would necessarily fall if the constitutional amendment could not be secured. This may be considered the central recommendation of the brief, but there are many other recommendations and many other things we point out in the brief that could be quite useful apart altogther from the constitutional amendment.

COMMISSIONER BALTZAN: I have just this Mr. Chairman: Gentlemen, I would like particularly to refer to your written brief here, and say only two things, and first of all your brief, to me, is very clear and straightforward and I might even say, and do so, scholarly. It is much better than a lot of non-commital statements, and

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Chairman: Gentlemen, I would like particularly to

I assume they represent your own positive opinions, which you are entitled to, as everybody else is. I have only one question at this moment: Something on page 9 is not too clear. You refer to an institution, and I think it has to do with the aged and infirm, and you say, after about eight or nine lines, that conditions are so bad that official requests by leaders of the labour movement to inspect the institution have been ignored, and the committee of the St. John's Trade and Labour Council which applied at the office of the infirmary for a guided tour of the institution was forbidden by the government to proceed. My question is, just for explanation and clarification, is it a public institution, a volunary institution, is it a government institution and by "government" I mean is it a governing body, or is it the official government of the Council of the city, or the government of the province of Newfoundland?

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MR. HORWOD: It is the provincial government. It is a very old building, over one hundred years old. It is a very old wooden building on Sudbury Street here in St. John's. It is used for the infirm, a home for the senile, aged. It is operated under, I believe, the Department of Welfare.

COMMISSIONER BALTZAN: Then it is a government institution?

Then you say that the committee of the St. John's Trade and Labour Council were refused. Do you know of any other representative bodies that were refused?

MR. HORWOD: No, I don't think so. But St. John's Trade and Labour Council at that time were quite deliberately carrying on a fairly violent public agitation for a new home for the aged and infirm, passing resolutions, introducing resolutions to the Newfoundland Federation of Labour, and was attempting to lead a movement for that. That was the time the request for the tour was refused.

COMMISSIONER BALTZAN: Thank you.

COMMISSIONER STRACHAN: One matter, sir, on page 5, the sentence under "Dental Health." May I enquire on what basis that statement is made? I would presume from that that your membership is entirely behind fluoridation.

MR. HORWOD: Well, speaking for the three of us who are present here, sir, we are certainly very much behind the fluoridation. The St. John's Trade and Labour Council, of which I was president last year, set up a committee to study this matter, and the committee made an unanimous recommendation in favour of fluoridation

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and in favour of bringing pressure to bear on the government of St. John's, the city government, to have the city water supply fluoridated. We had a local dentist who is something of an expert on the matter appear before the Council and give evidence on this matter, and we studied the anti-fluoridation propaganda as well as the pro-fluoridation propaganda, and the committee didn't make a final report, but there was an interim conclusion that we should use every means we could employ to fluoridate the water supply of Newfoundland.

COMMISSIONER STRACHAN: Thank you very much, but that doesn't answer my question regarding the St. Lawrence.

MR. HORWOD: Both the present deputy Minister and the present Minister have, I think, mentioned to me St. Lawrence and said what a natural fluoridated water supply could do. I am quite sure that is the position with the present Minister of Health.

COMMISSIONER STRACHAN: You suggest that Newfoundland should have at least five more dentists. Have you any suggestions as to how these dentists may be obtained and when and how they could be trained?

MR. HORWOD: These are technical problems, sir, and we certainly are not technical specialists in the matter of health. We point out we need them; it is up to the public health services to procure them, and if they are to be employed in the public health services, perhaps more attractive terms should be offered than are offered at the present time. Perhaps there is a shortage of dentists which cannot be cured unless we recompense them

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sufficiently. There are over 50,800 and something people.

COMMISSIONER STRACHAN: But you do recognize that at the present time, with personnel as it is, it is quite an impractical situation.

MR. HORWOD: Yes. It is certainly difficult. Maybe it would be possible to obtain more dentists from Europe. We have had one or two foreign dentists come here, people who were not qualified to practise on the mainland but who practise here. If we can't get dentists who are qualified to practise in Toronto, perhaps we could get people who could practise here.

THE CHAIRMAN: Do you think the people would be satisfied with the lower standard?

MR. HORWOD: Well, there are general practitioners and nurses on tour, and anyone who could fill a cavity would fill a great need in these places.

COMMISSIONER BALTZAN: I suppose the biggest cavity that you have is lack of dentists?

MR. HORWOD: That is right.

COMMISSIONER FIRESTONE: Mr. Chairman, this brief of the Newfoundland Federation of Labour is the most moving plea for a national health plan that we have so far encountered.

MR. HORWOD: Thank you very much.

COMMISSIONER FIRESTONE: And it is based on the need of coping with regional problems of health care. It is also well written. May I follow up a question, Mr. Chairman, which you yourself have pursued and see if we can get an answer from the representatives of the Newfoundland Federation of Labour.

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Sir, if there is a delay in obtaining a constitutional amendment, would you be in favour of preferring a national health plan or would you be in favour of proposals which would develop a plan on a provincial basis with whatever assistance may be recommended by the Commission to the Federal Government, be given by the Federal Government and to be obtained from the public at large?

MR. HORWOD: We certainly wouldn't be in favour of any deferral if it is possible to implement a plan on the national level, administered by the Federal Government, then certainly we should proceed with all haste to implement a plan under the Federal Government, with the use of the provinces as the Federal Government's agents in the matter of carrying out the services.

COMMISSIONER FIRESTONE: If I may turn to the next question. What are your objections to a contributory comprehensive medical health plan with contributions made by those who can afford to pay the premiums required?

MR. HORWOD: Well, this obviously would introduce a means test. You say contributions paid by those who can afford it. I think these were the words.

COMMISSIONER FIRESTONE: Yes, sir.

MR. HORWOD: Well, it has the effect which we object to in point 1 of our summary, that it divides the Canadian population into classes. It doesn't have the effect of preventing the person who must go through the means test to avoid paying something from the sense of ignominy. There is a matter of human dignity involved.

COMMISSIONER FIRESTONE: In other words, you

with whatever assistance may be recommended by the Commission to the Federal Government, be given by the Federal Government and to be obtained from the public at large.

MR. HOWOD: We certainly wouldn't be in favour of any deferral if it is possible to implement a plan on the national level, administered by the Federal Government, then certainly we should proceed with all speed

the matter of carrying out the services.

COMMISSIONER FIRESTONE: If I may turn to the next question, what are your objections to a compulsory comprehensive medical health plan with contributions made by those who can afford to pay the premiums required?

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COMMISSIONER FIRESTONE: In other words, you

are basing it on the point that public health is a matter of public right. Is that the point you are making?

MR. HORWOD: Yes.

COMMISSIONER FIRESTONE: Do I understand that you are in favour of a tax-supported programme?

MR. HORWOD: Yes.

COMMISSIONER FIRESTONE: Now, if such a tax-supported programme would involve higher income taxes payable by the industrial worker, would the Newfoundland Federation of Labour support such higher taxes?

MR. HORWOD: Yes, sir.

COMMISSIONER FIRESTONE: You say you are short of doctors, dentists and nurses, and in answer to the question of my fellow commissioner you suggest that this is perhaps a technical question. I am just wondering whether we could ask you to give a little further thought to the problem of how Newfoundland could obtain adequate health personnel. It has been presented to us that without these additional health personnel you can't provide those additional services. We are just wondering whether it would be possible for your federation to give a little further thought to this problem and to come forward in a supplementary submission with proposals, with specific proposals to the Commission of how the province of Newfoundland could come to grips with this problem, because obviously without more doctors, nurses and dentists and other medical personnel it would be difficult to really improve significantly the health standards, whatever financial recommendations may be made. Perhaps labour, as a very substantial user of medical services, may have

[illegible] right. Is that the point you are making?

MR. HORWOOD: [illegible]

COMMISSIONER FIRSTBROOK: Do I understand that you are in favour of a [illegible]

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some views on it, and we would like to have your views, if you could look into the matter further and let us have your views. The reason I say this is because the Province of Newfoundland has special problems which we have not encountered in other places in Canada. You talk about the question of standards. Well, what can be done and how it should be done and what specific recommendations do you have?

MR. HORWOD: We will take this matter under consideration. We cannot promise anything in advance, because it is a thing which the Department of Health has already examined at great length and they haven't found a solution, and we can't say we will, but we can look into it.

COMMISSIONER FIRESTONE: The professions are looking into it, but don't you think we could have the views of the Federation of Labour on such a question?

MR. HORWOD: Certainly.

COMMISSIONER FIRESTONE: Your answer is "Yes"?

MR. HORWOD: Yes.

THE CHAIRMAN: Mr. Horwod, let me put it to you this way. Do you think that there is anything which labour, or speaking of the organization of the Federation of Labour, can do to foster recruitment to the professions?

MR. HORWOD: That is an idea. It is possible. It is possible, yes.

THE CHAIRMAN: Would you take it under advisement for consideration, and if you come up with any ideas, would you include them in a supplementary submission?

some views on it, and we would like to have your views, if you could look into the matter further and let us have your views. The reason I say this is because the Province

[illegible]

encountered in other places in Canada. You talk about the question of standards. Well, what can be done and how it should be done and what specific recommendations do you

[illegible]

because it is a thing which the Department of Health has [illegible] solution, and we can't say we will, but we can look into it.

[illegible]

looking into it, but don't you think we could have the views of the Federation of Labour on such a questions

MR. HOWOOD: Certainly.

COMMISSIONER FIRESTONE: Your answer is "yes"?

MR. HOWOOD: Yes.

THE CHAIRMAN: Mr. Howood, let me put it to you this way. Do you think that there is anything within labour, or speaking of the organization of the Federation

[illegible]

It is possible, yes.

THE CHAIRMAN: Would you take it under

[illegible]

MR. HORWOD: Of course, recruitment to the professions doesn't answer our regional problem here.

THE CHAIRMAN: Well, recruitment to the professions in Newfoundland and services in Newfoundland.

MR. HORWOD: With strings attached, yes.

MR. GILLIES: Mr. Chairman, do you need this supplementary submission within a day or a week?

THE CHAIRMAN: Several months; have it by early spring. We are not asking you to give any offhand opinions or views. These are the studied and considered views we would like to have.

COMMISSIONER: FIRESTONE: If I may follow on, Mr. Chairman. If you are going to present a supplementary brief, and such a supplementary brief could quite appropriately be put in writing and presented to the Commission, although if you wish there will be hearings in Ottawa, but if you are providing us with such supplementary information, could we ask you to look at the numerous recommendations which you have in this submission before us and tell us what in your opinion the financial implications of the sum total of your recommendations are as far as the health care programme for the Province of Newfoundland is concerned? We are particularly interested in your views on the requirements of the Province of Newfoundland, how much it will cost, where the money is going to come from, and would you please add, when you discuss the question of financing, whether you feel some contribution should also be made by the people of Newfoundland for a health care programme in Newfoundland, and, if so, what contribution. Thank you very much.

[illegible]

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THE CHAIRMAN: Well, recruitment to the [illegible]

MR. HOSWOOD: With strings attached, yes.

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COMMISSIONER BALTZAN: Mr. Chairman, just one other point. I don't know who to put this to, one question or one thing for explanation for my own clarification or edification. From what we hear now or elsewhere the means test has become a sort of a contest. The question is: Are not income taxes imposed on the basis of earned means? In other words, a sort of an inverse type of means test. In principle, means tests are a prevailing system. In relation to what I have mentioned, it certainly is a form of means on which the earnings are taxed. Are not income taxes imposed on the basis of earned means? And means test doesn't seem so odious to me when it is applied, as it is here, applied in relation to taxes. We have heard so much about means tests and objections to it, and I cannot see any serious objection to means tests.

THE CHAIRMAN: Are you putting the question to Mr. Horwod, because I should say that there will be no asking and answering of questions by the Commissioners at this time.

COMMISSIONER BALTZAN: Then what is the objection to means tests to people who are able to pay? Let's say people who have means. What is the objection?

MR. HORWOD: The objection is quite simply stated. There is no objection at all to people who have the means of paying. The objection is to the people who have not the means being forced to apply for a service and they have to show if they can't pay for it. It is a form of humiliation. It is quite a different thing altogether in applying for a service and then having to prove you

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the means test has become a sort of a concept. The question is: Are not income taxes imposed on the basis of earned means? In other words, a sort of an income type of means test. In principle, means tests are a prevailing system. In relation to what I have mentioned it certainly is a form of means on which the estates are taxed. Are not income taxes imposed on the basis of earned means? And means test has been no objections to me when it is applied, as it is here, applied in relation to taxes. We have heard so much about means tests and objections to it, and I cannot see any serious objection to means tests.

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COMMISSIONER MILNEAR: Then what is the objection to means tests to people who are able to pay? Let's say people who have means. Mr. is the objection? [illegible] objection is quite simply stated. There is no objection at all to people who have the means of paying. The objection is to the people who have not the means being forced to apply for a service and they have to show it they can't pay for it. It is a form of humiliation. It is quite a different thing altogether

can't pay for it.

COMMISSIONER BALTZAN: In other words, you are letting the people off the hook, as it were?

MR. HORWOD: Yes. Why not? They pay anyway.

COMMISSIONER McCUTCHEON: Mr. Chairman, I am referring to the top of page 2 of the brief, and I am interested in the broad statement covered by several sentences which would seem to indicate that Canada is a second-rate country, hasn't met its obligations, It is compared unfavourably to China, India and Luxemburg and a number of other countries, all of which are alleged to have a comprehensive programme of medical care extended to the citizens and financed out of taxation. Australia is mentioned, and Australia is a country which is very much like Canada; it is a member of the Commonwealth, it is a federation of state governments. I would just like to ask Mr. Horwod or Mr. Gillies: How familiar are you with the health plan of Australia?

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COMMISSIONER McINTYRE: In other words [illegible]

[illegible]

COMMISSIONER McCUTCHEON: Mr. Chairman, I am referring to the top of page 2 of the brief, and I am interested in the broad statement covered by several sentences which would seem to indicate that Canada is a second-rate country, hasn't met its obligations. It is compared unfavourably to China, India and Luxembourg, and a number of other countries. All of which are alleged to have a comprehensive programme of medical care extended to the citizens and financed out of taxation. Australia is mentioned, and Australia is a country which is very much like Canada; it is a member of the Commonwealth, it is a federation of state governments. I would just like to ask Mr. Howard or Mr. Gillies: How familiar are you with the health plan of Australia?

MR. HORWOD: The information in this paragraph, sir, was simply taken from one of the publications of the United Nations, I have forgotten which, which listed summarized health services in the countries of the world, and we certainly haven't gone into the details of the national health plans of all these separate countries that we mentioned.

COMMISSIONER McCUTCHEON: If I were to suggest to you that the Australian Health plan provides an element of co-insurance and contributions from the persons benefitting from the plan, you would not argue?

MR. HORWOD: No.

COMMISSIONER McCUTCHEON: But that is the statement you made, that a comprehensive medical health care plan financed out of taxation. The implication is that it is the kind of plan which you are asking for in the next paragraph, entirely financed out of taxation, with no deterrents and no co-insurance. You are not suggesting that these countries have the kind of plan, or that they provide the service you are requesting?

MR. HORWOD: No, in China I am sure the national health plan is quite primitive.

COMMISSIONER McCUTCHEON: I would have thought it was, but I don't know enough about China.

COMMISSIONER FIRESTONE: To complete the questioning that I had pursued a little earlier, may I have an answer from Mr. Horwod that the information I have requested on financing the plan will be forthcoming in the supplementary submission?

MR. HORWOD: Yes, sir, we will do that.

[illegible]

[illegible]

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the national health plans of all these separate countries that we mentioned.

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COMMISSIONER MCCUTCHEON: But that is the statement you made, that a comprehensive medical health care plan financed out of taxation. The implication is that it is the kind of plan which you are seeking for in the next paragraph, entirely financed out of taxation, with no deterrents and no co-insurance. You are not suggesting that these countries have the kind of plan, or that they provide the service you are requesting?

MR. HORWOOD: No, in China I am sure the national health plan is quite primitive.

COMMISSIONER MCCUTCHEON: I would have thought it was, but I don't know enough about China.

COMMISSIONER HIGGINSON: To complete the questioning that I had pursued a little earlier, may I have an answer from Mr. Horwood that the information I have requested on financing the plan will be forthcoming in the supplementary submission?

MR. HORWOOD: Yes, sir, we will do that.

THE CHAIRMAN: Thank you very much, gentlemen. The next submission will be from the Newfoundland Society for the Care of Crippled Children and Adults. It will be exhibit number 26.

---EXHIBIT NO. 26: Submission of the Newfoundland Society for the Care of Crippled Children and Adults.

SUBMISSION OF

THE NEWFOUNDLAND SOCIETY FOR THE CARE OF CRIPPLED CHILDREN AND ADULTS

APPEARANCES:

MR. ERIC E. EWING	-	President
DR. A.E. SHAPTER	-	Medical Director
MR. HUBERT W. HALL	-	Executive Secretary

SUMMARY OF THE DRAFT SUBMISSION

Of The

NEWFOUNDLAND SOCIETY FOR THE CARE OF CRIPPLED CHILDREN AND ADULTS

To The

ROYAL COMMISSION ON HEALTH SERVICES.

Mr. Chairman and members of the Royal Commission and Health Services. It is with pleasure that the Newfoundland Society for the Care of Crippled Children and Adults presents herewith a summary of the enclosed brief on health services in Newfoundland in so far as rehabilitation of Crippled children and adults is concerned.

The Newfoundland Society for the Care of Crippled Children and Adults operates Newfoundland's only rehabilitation centre which is known as the Sunshine Camp Children's Rehabilitation Centre. The Board of Directors of the Society which is also the Board of Governors, is made up of a voluntary group of professional and business men who direct and govern the rehabilitation centre, and who are responsible for the raising of funds through various means to operate the Centre. The Centre was established for crippled children in 1954 and has grown steadily in its expansion of services, the most notable increase in the expansion being noted since 1959. At the present time the Sunshine Camp Rehabilitation Centre provides treatment and evaluation services, both on an In Patient and Out Patient basis for those children under about the age of sixteen who suffer from such diseases as poliomyelitis,

SUMMARY OF THE BRIEF SUBMISSION

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Board of Directors of the Society which is also the Board of Governors, is made up of a voluntary group of professional and business men who direct and go into the rehabilitation centre, and who are responsible for the raising of funds through various means to operate the Centre. The Centre was established for crippled children in 1954 and has grown steadily in its expansion of services, the most notable increase in the expansion being noted since 1959. At the present time the Bonaventure Camp Rehabilitation Centre provides treatment and evaluation services, both on an In Patient and Out Patient basis for those children under about the age of sixteen who suffer from such diseases as poliomyelitis,

cerebral palsy, spina bifida, amputees, neuromuscular diseases in children, rheumatoid arthritis, speech defects, chronic chest diseases, etc. These services are carried out by a medical staff consisting of a group of medical and surgical specialists in the city of St. John's, together with the full time professional staff consisting of a Social Worker, Physiotherapists, Occupational Therapist, activities of daily living nurse and Speech Therapist.

The financial operation of the Rehabilitation Centre is made possible by a per diem rate through the Provincial Hospital Insurance Scheme, by public subscription to two campaigns namely, the March of Dimes and Easter Seals, and through some Federal Children's Health Grants obtained through the Provincial Department of Health, and as well as from the St. John's Rotary Club Radio Auction. At the present time the small accumulated surplus of the Society, which was meant to be the start of a new and larger Centre, will probably have to be drawn upon this year as the total operating expenses are expected to be well above the total revenue. Largely responsible for this deficit is the great number of Out Patients which we have of necessity to treat as Out Patients because of the lack of In Patient facilities.

The progress since early 1959 has been described in the accompanying brief in detail. Because of our increased case finding and social services, more and more rehabilitation needs are being discovered. The impressive work that is being done at the Centre by

[illegible]

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[illegible]

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the Staff is even more remarkable when the facilities available are studied, and the frustration in the work grows as we learn more and more about the great need for rehabilitation in Newfoundland and the appalling lack of means to provide it.

The facilities are rather primitive and the building itself which is situated seven miles in the country from St. John/s is an outdated single story, wooden structure in which are crowded the staff and the patients in working areas which normally should be three times as large. Further expansion of this building, which would be the cheapest way of expanding the facilities, cannot be carried out because of the state of the land on which the present building exists. The transportation of patients and staff to and from St. John's is a problem produced by the fact that the Centre is situated seven miles from the city, and, because it is on a secondary road, the Centre is often inaccessible for several days at a time following a severe snow storm. Some of the equipment at the Centre is modern and useful, but in general it can be said that a great amount of the essential equipment for a rehabilitation Centre is absent, and even if it could be obtained, there would be no room for it.

The Sunshine Camp Children's Rehabilitation Centre has reached the limit of what it can do with these present facilities, and with good fortune it may be able to carry on for a while under these circumstances but it will require very little misfortune to have the services decreased, in quantity and quality. Immediate

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[illegible]

Centre has reached the limit of what it can do with these present facilities, and if, good fortune it may be able to carry on for a while under these circumstances but

action is necessary to overcome this deplorable situation in Newfoundland's only Rehabilitation Centre.

In the section of this brief on recommendations much more detail is provided, but in summary we would like to say that our Centre needs at once a fifty bed In Patient unit for children, and facilities for one hundred and fifty Out Patients a week. The space for this Centre is already in existence, on the first floor of the presently vacant hospital at Pepperrell, the former U.S. Air Force Base, which is located within the city of St. John's. Whether the Provincial or Federal Government becomes the landlords of this property, is not important from the point of view of our rehabilitation needs. The important thing is that this building which has been vacant for almost a year is still being maintained to prevent deterioration, but it is empty. It could at once be easily and cheaply reactivated into an active rehabilitation centre for children. This is an immediate need.

It is recommended that whether the Centre operates in its present situation or whether it is fortunate enough to operate at Pepperrell Hospital, the per diem rate from the Provincial Health Insurance should be increased substantially, a fifty percent increase being considered the minimum amount required. As well, provision for payment of Out Patient Services at the Centre by the Provincial Health Insurance should be instituted at once.

The recognition by the Federal Government of the Sunshine Camp Children's Rehabilitation Centre as a

In the section of this brief [illegible] recommendations [illegible] more detail is provided, but in summary we would like to say that our Council needs at once a fifty bed In Patient unit for children, and facilities for one hundred and fifty Out Patients a week. The space for this Centre is already in existence, on the first floor of the presently vacant hospital at Pepperrell, the former U.S. Air Force Base, which is located within the city of St. John's. Whether the Provincial or Federal Government becomes the landlords of this property, is not important from the point of view of our rehabilitation needs. The important thing is that this building which has been vacant for almost a year is still being maintained to prevent deterioration, but it is empty. It could at once be easily and cheaply reactivated into an active rehabilitation centre for children. This is an immediate need.

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The recognition by the Federal Government of the Summerside Camp Children's Rehabilitation Centre as a

bona fide institution is recommended as that step will help to procure more funds from the Federal Grants for Crippled Children and decrease the operating expenses by avoiding taxes and duties on many of our essential operating items.

It is recommended that the erection of a two hundred bed rehabilitation Centre, with equal division of the beds for children and adults be started and completed within the next five years. The funds for such a Centre should be procided fro by increased Federal grants for rehabilitation to the Province and the Provincial contribution be correspondingly increased. As well, such bodies as the Workmen's Compensation Board of Newfoundland and the Department of Veterans Affairs in Newfoundland be stimulated to providing part of the funds for this Centre.

Staffing of this Centre should be started now, by a Federal sponsored recruitment effort to encourage the high school and university students to train for the various professions required in a Rehabilitation Team. Increased grants and bursaries for these trainees will have to be provided through Federal Funds, but this step is an immediate essential one if the required personnel in five years are to be available.

The Provincial Government should seek for interested medical graduates to train in Physical Medicine, and through Federal Health Grants, provide the training for these people, and when such people are trained and available for this Province, to insure these people of an adequate income and adequate facilities with

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Staffing of this Centre should be started now by a Federal sponsored recruitment effort to encourage the high school and university students to train for the various professions required in a rehabilitation Centre. Increased grants and bursaries for these training will have to be provided through Federal Funds, for this step is an essential one if the required personnel in this area are to be available.

The Provincial Government should seek for increased medical quantities to train in Physical Medicine, and through Federal Health Grants, provide the training for these people, and when such people are trained and available for this Province, to insure these people of an adequate income and adequate facilities with

which to perform their work. Other recommendations include improved Orthopaedic Hospital facilities, the provision of a suitable Institution for these disabled children who live outside St. John's, and who because of their disability and local conditions cannot attend school, or cannot even be given the simple home program on which they are placed while at the Centre. Much of the good work at the Centre is lost because of the lack of this facility, and one or two of the many vacant buildings at Pepperrell would again fulfil this great need. It is further recommended that, included in the program for the future, that the provision of work shops for training of disabled personnel be considered as an essential aspect of the rehabilitation program. Again, this Society would like to point out the facilities which are available at Pepperrell, the former U.S. Air Force base, as just behind the hospital is a vacant building which was one time a spare time work shop for the armed services personnel. We would like to point out the economical advantages gained by the utilization of the buildings at Pepperrell for rehabilitation needs.

Draft Submission

of the

Newfoundland Society for the Care of Crippled Children

and Adults.

Operating

The Sunshine Camp Children's Rehabilitation Centre

St. John's, Newfoundland.

to the

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Brief Submission

of the

Newfoundland Society for the Care of Crippled Children

and Adults

Operation:

The Janeway Crippled Children's Rehabilitation Centre

to the

Royal Commission on Health Services

Mr. Chairman and Members of the Royal Commission on Health Services:

The Newfoundland Society for the Care of Crippled Children and Adults, which is the Newfoundland Chapter of the Canadian Foundation for Poliomyelitis and Rehabilitation and the Newfoundland Branch of the Canadian Council for Crippled Children and Adults, is pleased to have been given the opportunity to present a brief on Health Services in Newfoundland insofar as services for the rehabilitation of crippled Children and Adults are concerned.

The Newfoundland Society for the Care of Crippled Children and Adults is a lay organization which functions under the guidance of the Board of Directors, which is a voluntary group of business and professional men. The Society operates the Sunshine Camp Children's Rehabilitation Centre and was formerly known as the Sunshine Camp Association. The Sunshine Camp Children's Rehabilitation Centre came into existence as a rehabilitation centre for crippled children in 1954. The building which is now being utilized as the Rehabilitation Centre was originally a home built for under privileged children so that they could spend a few weeks each year in the country, and on this basis was operated by the St. John's Rotary Club. In 1953 Newfoundland was struck by a very severe Poliomyelitis epidemic, and as a result the Sunshine Camp Children's Rehabilitation Centre came into existence as a centre devoted to the rehabilitation of crippled children. Up until 1959 the Centre wss known as the

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Sunshine Camp and was operated by the Sunshine Camp Association. However, at that time the Newfoundland Society for the Care of Crippled Children and Adults was formed and the name of the centre was changed to the Sunshine Camp Children's Rehabilitation Centre. The building is still owned by the St. John's Rotary Club but the new organization now operates it entirely. Since 1954 the work within the scope of the Camp has increased, and this increase has been more decidedly increased since late 1958 and early 1959. At the present time the Centre cares for total rehabilitation problems which fall into the category of Poliomyelitis, Cerebral Palsy, Spina Bifida and other neuromuscular disorders in children, rheumatoid arthritis, speech defects, chronic chest diseases, amputees and a miscellaneous group of diseases which may effect the child and produce a serious disability. It is the general policy to keep the attention focused on the children under the age of sixteen years, though as the present patients reach the age of sixteen years many of them are kept on for treatment because of the lack of facilities elsewhere.

The Sunshine Camp Children's Rehabilitation Centre, with thirty-one beds, is the only centre in the Province of Newfoundland providing rehabilitation services for the disabled and at the present time is confined because of lack of space, personnel, and finances to operating a children's rehabilitation programme. Extension of the programme of the Society into the Adult Rehabilitation field is planned for t e future and at the present the only contribution it makes to adult rehabilitation is in

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training fields by such means as the provision of correspondence courses, by the provision of some equipment for training, e.g. typewriters, and by the purchasing of equipment to provide a means of independent wage earning for a disabled adult. It is felt that the present need for total rehabilitation care for children is the more urgent pressing need at the present time, and we have chosen for the time being to continue along these lines until such time as our services can be expanded.

There are approximately sixteen hundred children, who require rehabilitation services, registered at this Rehabilitation Centre. There are an estimated twenty-five hundred known physically disabled children in Newfoundland and this number is expected to increase in the future because of better medical care in the pre-natal, natal and post natal periods, and in early childhood. It is the policy of this Society to register those children who are in need of total rehabilitative services and as a result the roster is being continuously changed as cases with the less severe forms of deformities, are being placed on the inactive list, and referred to the clinics and private physicians for care. As an example the treatment of tuberculous joint disease, is now no longer considered in the province of the Rehabilitation Centre, but rather a case such as a spina bifida with gorss involvement of the lower extremities, or a quadraplegic cerebral palsy case or the more severely involved infantile and juvenile muscular dystrophies are treated at the centre. However, more new cases are added each year than are placed on the

correspondence courses, by the provision of some equipment for training, e.g. typewriters, and by the purchasing of equipment to provide a means of independent wage earning for a disabled adult. It is felt that the present need for total rehabilitation care for children is the

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children in Newfoundland and this number is expected to increase in the future because of better medical care in the pre-natal, neonatal and post natal periods, and in early childhood. It is the policy of this Society to register those children who are in need of total rehabilitative services and as a result the roster is being continuously enlarged as cases with the less severe forms of deformities, are being placed or the incentive lies preferred to the clinics and private physicians for care. As an example the treatment of tuberculous joint disease, is now no longer considered in the province of the Rehabilitation Centre, but rather a case such as a spina bifida with gross involvement of the lower extremities, or a quadraplegic cerebral palsy case or the more severely involved infantile and juvenile muscular

cases are added each year than are placed on the

inactive list, and many of the previously considered inactive cases have been reactivated by further enquiry into the particular case. To illustrate this, in the period between January to June 1960, 271 new cases were opened, and 5 old cases were reopened, giving a total of 276 cases. The total number of cases closed or considered inactive during that period of time was 99. Between the period of July 1st., 1960 to March 31st., 1961, 414 new cases were registered and 36 old cases reopened. This new total comes to 627 additional cases, while the number of cases closed or considered inactive during that period of time was 293.

The medical policy of this Rehabilitation Centre is under the direction of the Medical Advisory Board whose recommendations are presented to the Board of Directors, and this Board of Directors is the Board of Governors of the Centre. These recommendations are considered by the Board of Directors and acted upon as deemed advisable. The comprehensive medical care programme of the Centre for both in-patients and out-patients is carried out by a part time medical staff of Specialists, all practising in St. John's, and this programme is under the direction of the Medical Director. These Specialists receive no remuneration from the Society for their services. Also under the direction of the Medical Director is a staff who provides the direct rehabilitation services, and these services include physiotherapy, occupational therapy, speech therapy, activities of daily living, social services, nursing services and education. All of these services

inactive list, and many of the previously considered inactive cases have been reactivated by further enquiry into the particular case. To illustrate this, in the period between January to June 1960, 271 new cases were opened, and 5 old cases were reopened, giving a total of 276 cases. The total number of cases closed or considered inactive during that period of time was 94. Between the period of July 1st., 1960 to March 31st., 1961, 114 new cases were registered and 35 old cases reopened. This new total comes to 327 additional cases, while the number of cases closed or considered inactive during that period of time was 293.

is under the direction of the Medical Advisory Board whose recommendations are presented to the Board of Directors, and this Board of Directors is the Board of Governors of the Centre. These recommendations are considered by the Board of Directors and acted upon as deemed advisable. The comprehensive medical care programme of the Centre for both in-patients and out-patients is carried out by a part time medical staff of Specialists, all practising in St. John's, and this programme is under the direction of the Medical Director. These Specialists receive no remuneration from the

of the Medical Director is a staff who provides the direct rehabilitation services, and these services include psychotherapy, occupational therapy, speech therapy, activities of daily living, social services, nursing services and education. All of these services

are provided by an employed professional staff making up a complete rehabilitation team.

In detail the medical staff consists of at the present time an orthopaedic surgeon who acts as a Medical Director, a Neurologist, Psychiatrist, Pediatrician, a General Surgeon, an Eye and O.T.L. Specialist, a Neurosurgeon, a Neurologist, a Plastic Surgeon, a Radiologist and a Dentist. Prior to July 1st., 1961, the Centre had the privilege of being directed by a Physiatrist, who has been largely responsible for the tremendous increase in the overall programme since 1959. In his absence the Assistant Medical Director has taken over the duties of the Medical Director, and he is also a practising Orthopaedic Surgeon in St. John's.

The following is a detailed description of the services provided at the Centre:-

(1) Total Evaluation. Evaluation is carried out by the rehabilitation team consisting of the Orthopaedist, the Neurologist, Physiotherapists, Occupational Therapist, Social Worker, Nurses, ADL Nurse, and Speech Therapist. Other medical consultants as previously listed are called in when a case necessitates his opinion. Psychological evaluation, at present, is not being done in the Centre as such, but our patients receive this evaluation through the facilities of the Hospital for Mental and Nervous Diseases in St. John's as out-patients. This total evaluation service is provided on an out-patient and in-patient basis.

(2) Treatment. Treatment is provided for in the

are provided by an employed professional staff making

In detail the medical staff consists of at the present time an orthopaedic surgeon, who acts as a Medical Director, a Neurologist, Psychiatrist, Pediatrician, a General Surgeon, an Eye and O.T.L. Specialist, a Neurosurgeon, a Neurologist, a Plastic Surgeon, a Radiologist and a Dentist. Prior to July 1st., 1961, the Centre had the privilege of being directed by a Physiatrist, who has been largely responsible for the tremendous increase in the overall programme since 1959. In his absence the Assistant Medical Director has taken over the duties of the Medical Director, and he is also a practising Orthopaedic Surgeon in St. Louis.

The following is a detailed description of the services provided at the Centre:-

(1) Total Evaluation. Evaluation is carried out by the rehabilitation team consisting of the Orthopaedic [illegible] Therapist, Social Worker, Nurses, ADL Nurse, and Speech Therapist. Other medical consultants as previously listed are called in when a case necessitates his opinion. Psychological evaluation, at present, is not being done in the Centre as such, but our patients receive this evaluation through the facilities of the Hospital for Mental and Nervous Diseases in St. Louis as out-patients. This total evaluation service is provided on an out-patient and in-patient basis.

(2) Treatment. Treatment is provided for in the

nature of physiotherapy, occupational therapy, activities of daily living, and speech therapy. Except for speech therapy, this treatment is provided for in-patients and out-patients.

(3) Education. Education is provided for by a single female teacher for in-patients and out-patients, as the out-patients usually spend the most of the day at the centre. Very occasionally a patient comes in merely for education, but this is only in very exceptional cases.

(4) Survey-Case Finding. One nurse is considered the survey nurse, and together with the social service department provides regular surveys covering most of the Province, and the case finding program is carried out by the social worker and a physiotherapist, who visits the cases whenever possible prior to her coming to the centre for complete evaluation.

(5) Social Services. The social service, department being extremely active, is responsible for the preliminary evaluation of many aspects of each case, provides for transportation arrangements, seeks and obtains welfare benefits where indicated, arranges home education by correspondence courses and by negotiations with local schools and school boards, and very actively investigates old cases, investigates new cases and seeks new cases. Our single social worker for example travelled in this Province between July 1st., 1960 and March 31st., 1961 a total of 3,129 miles by road.

(6) Psychological Services The psychological

[illegible] except for speech therapy, this treatment is provided for in-[illegible]

(3) Education. Education is provided for by a single female teacher for in-patients and out-patients, as the out-patients usually spend the most of the day at the centre. Very occasionally a patient comes in merely for education, but this is only in very exceptional cases.

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service provided by the Centre is confined to a psychological evaluation of a patient, and only through the facilities of the St. John's Hospital for Mental and Nervous Diseases. There are no psychological facilities at the Centre itself.

(7) Nursing Services The Director of Nursing Services who acts as a coordinator of all aspects of the total rehabilitative programme, also directs many aspects of the function of the Centre other than Nursing. She is responsible for the quality of nursing care, the arrangement of clinics, and direct supervision of the transportation.

(8) Dental Services The consultant dentist provides dental care to the in-patients at the Centre, and these services are provided in this dentist's own office, to which the patients are brought. There are no dental facilities as such at the Centre, itself.

(9) Travelling Clinics. Within the past year this aspect of evaluation by the Rehabilitation Team has been started, and to date, five centres have been visited by the Rehabilitation Team, consisting of the Director of Nursing Services, two Physicians, (an Orthopaedist, Physiatrist or Neurologist), Physiotherapist, Occupational Therapist, Activities of Daily Living Nurse, Social Worker, and Speech Therapist.

(10) Speech Therapy. At the present speech therapy is being conducted at the Centre on in-patients only by an elocutionist, who works under the supervision of a speech therapist. The Speech Therapist is employed in St. John's by the Provincial Department of

provided by the Centre in co-ordination to a

the facilities of the St. John's Hospital for mental

facilities at the Centre itself.

(7) Care. The Director of Nursing Services who acts as a coordinator of all aspects of the mental rehabilitative programme, also directly supports of the function of the Centre under the Nursing. She is responsible for the quality of nursing care, the arrangement of clinics, and direct supervision of the transportation.

(8) Dental Services. The consultant dentist provides dental care to the patients at the Centre, and these services are provided in the dental office, to which the patients are brought.

(9) Travelling Clinics. Within the psychiatric aspect of evaluation by the Rehabilitation Team has been started, and to date, five cases have been visited by the Rehabilitation Team, consisting of the Director of Nursing Services, two Physicians, (an Orthopaedist, Physiatrist or Neurologist), Physiotherapist, Occupational Therapist, Activities of Daily Living Nurse, and Social Worker.

(10) Speech Therapy. At the present speech therapy is being conducted at the Centre on an hourly basis by a speech therapist. The Speech Therapist is employed on a Sessional by the Provincial Department of

Health.

(11) Transportation. Transportation is provided for both in-patients and out-patients. In-patient transportation is necessary for the various diagnostic procedures necessary but obtainable only in the city hospitals, and for out-patients in order to transport them to and from the Centre for daily treatment, and transporting the out-of-town out-patients who come for evaluation and follow-up clinics, from various depots of transportation such as the Railway Station and Bus Depots. Transportation is a large problem in our Centre because of its distance of seven miles from St. John's.

(12) Direct Services. The direct services which the society provides through the centre include braces, prescription boots, prostheses, corsets, wheel chairs, crutches and spectacles. These services are supplied free of charge to the patients. At the present time even though a number of patients require them, hearing aids cannot be provided. This is because of the great expense involved.

(13) Summer Recreational Programme. This service has been in action for two years, and is considered to be an esstial and important aspect of the treatment of the totally disabled child. It has been a great success so far and will be continued.

(14) Salk Vaccine. The Newfoundland Society for the Care of Crippled Children and Adults has been responsible for providing many Salk Vaccine Programmes in St. John's and six other areas in Newfoundland over the

[illegible] Transportation is provided [illegible] transportation is necessary for a various organizations because necessary but obtainable only in the city capitals, and from out-patients to order to transport them to and from the Centre for daily treatment, and transporting the out-of-town out-patients the case for examination and follow-up clinics. Some organizations of transportation such as the Military Section of the Depots. Transportation is a major problem in our country because of the distance of rural areas from centres.

(d) Dental Service. The dental services and the society provides dentures, one in the [illegible] [illegible] free of charge to the patients. A case presented [illegible] even though a number of patients require dentures [illegible] which cannot be provided. This is because of the [illegible]

[illegible] service has been in action for two years, and is considered to be an essential and important aspect of the treatment of the mentally disabled child. It has been a great success [illegible] and will be continued.

(4) Bank Vacation. The Newfoundland Society for the Care of Crippled Children and Adults has been responsible for providing many Bank Vacation programs [illegible] St. John's and six other areas in Newfoundland over the

past two years. In the twelve month period between July of 1959 and June of 1960, a total of 44,000 injections were given free of charge to the general public.

Finances.

The cost of the operation of the Sunshine Camp Children's Rehabilitation Centre is financed by public subscription to two campaigns, namely the March of Dimes, and Easter Seals, which are conducted annually by the Newfoundland Society for the Care of Crippled Children and Adults, and through the Provincial Hospital Insurance Scheme at a per diem rate of $8.50 for each occupied bed. Other sources of revenue are through the Federal Children's Health Grants which are obtained through the Provincial Government and in 1960 consisted of $7,600. And as well the St. John's Rotary Radio Auction which is an annual event, provides some of the revenue.

This Society recognizes that without the present revenue from the Provincial Hospital Insurance Scheme and the Federal Children's Health Grants, operation of our Centre would not at all be possible.

The cost of the operation of the Centre for the fiscal year ending 31st of March 1961 was approximately $135,000 and the total revenue was $154,000. Because of added expenditures the estimated operating expenses for the year ending March 1962 will be $182,000 with an expected income of $176,000. This increased income is due mainly to the increase per diem rate from $6.50 to $8.50. The increase in operating expense is due

[illegible]

[illegible]

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[illegible]

The cost of the operation of the Sunshine Camp Children's Rehabilitation Centre is financed by public subscriptions to two campaigns, namely the March of Dimes, and Easter Seals, which are conducted annually by the Newfoundland Society for the Care of Crippled Children and Adults, and through the Provincial Department Schemes at a per diem rate of $8.5 for each occupied bed. Other sources of revenue are through the Federal Children's Health Centre Grants which are obtained through the Provincial Government in the amount of $7,000 and as well the St. John's Rotary Radio Auction which is an annual event, which is one of the revenue

[illegible]

increased revenue from the Provincial Hospital Insurance Scheme and the Federal Government Health Grants, operation of our Centre would be all on paying

The cost of the operation of the Centre for the fiscal year ending 31st of March 1961 was approximately [illegible]

[illegible]

for the year ending March 1962 will be difficult with an expected income of $75,000. This increase in [illegible]

[illegible]

to $4.40. The increase in operating expenses is due

mainly to increase in out-patient services provided. This increase in out-patient services has been necessitated by the lack of in-patient facilities and therefore has made it necessary to increase the staff, transportation facilities and housekeeping facilities. Another direct result of the increase in out-patient load is the greater number of appliances which are being provided.

IT WILL BE WELL TO NOTE HERE THAT THE REHABILITATION CENTRE DOES NOT RECEIVE ANY REMUNERATION FROM THE PROVINCIAL HOSPITAL INSURANCE SCHEME FOR OUT-PATIENT TREATMENT.

At the present time this Society has been studying the possibility of the building of a new and larger centre but it would appear at the present time , as the expenditures are beginning to outweigh the revenue, the small surplus which has been accumulated will soon be eliminated. For the time being and for a considerable while to come, this Society will not be able to make any great contribution towards the provision of a new and larger centre which is necessary for adequate rehabilitation of the disabled childred in Newfoundland.

Progress.

During the past five years and more noticeably within the past three years there has been a tremendous increase in the services provided by the rehabilitation centre. In 1957 there were 63 patients admitted while in 1960, 140 patients were admitted to the Centre. There were 22 clinics held in 1957 whereas in 1960, 70 clinics

[illegible]

[illegible]

[illegible]

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Progress.

During the past five years and more noticeably within the past three years there has been a tremendous increase in the services provided by the rehabilitation centre. In 1957 there were 63 patients admitted while in 1960, 140 patients were admitted to the Centre. There were 22 clinics held in 1957 whereas in 1960, 40 clinics

were held. A total of 41 patients were evaluated in 1957 whereas 274 were evaluated in 1960. In 1957 no orthopaedic procedures were performed whereas in 1960, 71 orthopaedic procedures were performed on in-patients. There has been a corresponding increase in the number of appliances provided, and in the number of treatments on an out-patient and in-patient basis. The out-patient load at present is 70 patients per week as compared to 10 per week in 1958. For example our present total number of treatments in the physiotherapy department runs well over 7,500 per year. The addition of a division for activities of daily living (ADL), which is being conducted by a nurse who has been trained especially for this, the provision of a social service division with a very active social worker, the provision of a speech and audiologist service, and the provision of an occupational therapy department, all reflect the great strides that have been made. However, the services at present being rendered though impressive when one considers the facilities available for their production is not nearly sufficient to meet the requirements for children alone, and when the adult aspect is considered the lack of services to the population of Newfoundland as a whole is appalling. The cost of the operation has increased from $55,000 in 1955 to $135,000 in 1960).

Present Facilities.

The Sunshine Camp Children's Rehabilitation Centre is situated seven miles from St. John's and consists of a wooden single story structure which was originally built in 1937. There have been two additior

A total of 41 patients were evaluated in 1957 whereas 274 were evaluated in 1960. In 1957 no orthopaedic procedures were performed whereas in 1960

There has been a corresponding increase in the number of appliances provided, and in the number of prosthesis on an out-patient and in-patient basis. The out-patient load at present is 70 patients per week as compared to 10 per week in 1958. For example our present total number of treatments in the physiotherapy department runs well over 7,500 per year. The addition of a division for activities of daily living (ADL) which is being conducted by a nurse who has been trained especially for this, the provision of a social service division with a very active social worker, the provision of a speech and audiological service, and the provision of an occupational therapy department, all reflect the great strides that have been made. However, the services at present being rendered though impressive when one considers the facilities available for their production is not nearly sufficient to meet the requirements for children alone, and when the adult aspect is considered the lack of services to the population of Newfoundland as a whole is appalling. The cost of the operation has increased from $55,000 in 1955 to $135,000 in 1960).

The Sunshine Camp Children's Rehabilitation Centre is situated seven miles from St. John's and consists of a wooden single story structure which was initially built in 1937. There have been two additions

namely a younger patient's ward and an occupational therapy department. The ground on which it is situated provides no room for any further building expansion, and the situation away from the Centre of St. John's produces many and varied problems especially from the point of view of transportation. The present total floor space of the Centre consists of 6,000 square feet and is roughly divided into 860 square feet for physiotherapy, 480 square feet for occupational therapy, 200 square feet for education, 70 square feet for social service, 70 square feet for acitivities of daily living, and the rest being divided into bed and living space and associated services, plus offices. For a 31-bed rehabilitation centre the minimum requirement would be approximately 18,000 square feet if operations were carried out at the present existing level. Even this would not provide us with the many needed areas, but it would provide a reasonable increase so that one could, with a reasonable amount of comfort, maintain the present programme.

The present building itself is extremely overcrowded. A very small dining room measuring 16' x 6' with a single long bench like table also doubles as a dishwashing area. The kitchen off this is a little larger and the pantry off this provides a relatively small space for the storage of food. The physiotherapy department is overcrowded and also serves as a place in which to carry on out-patient clinics. It is approximately one-third of the required space for our in-patient load, completely disregarding our out-patient

namely a room for patients ward and an occupational therapy department. The ground on which it is situated provides no room for any further building expansion, and the situation away from the Centre of St. John's produces many and varied problems especially from the point of

of the Centre consists of 6,000 square feet and is roughly divided into 600 square feet for physiotherapy, 480 square feet for occupational therapy, 400 square feet for education, 70 square feet for social service, 70 square feet for activities of daily living, and the rest being divided into bed and living space and associated services, plus offices. For a 41-bed rehabilitation centre the minimum requirement would be approximately 15,000 square feet if operations were carried out at the present existing level. To this would not provide us with the many needed areas, but it would provide a reasonable increase so that one could, with a reasonable amount of comfort, maintain the

The present building itself is extremely overcrowded. A very small dining room measuring 16' x 6' with a single long bench like table also doubles as a

lounge and the pantry off this provides a relatively small space for the storage of food. The physiotherapy department is overcrowded and also serves as a place in

approximately one-third of the required space for our

load. The classroom consists of only 200 square feet, and with wheel chairs and stretchers, conditions soon become very overcrowded and therefore a great deal of teaching has to be done on the ward. The main ward for the older children consists of approximately 1,200 square feet and is divided by a curtain down the centre between the boys and girls. During the day it acts as an indoor recreation area, and as a place for the teacher to teach the pupils who cannot fit into the small room, provides space for the speech therapist to visit the patients, (and this in itself is far from ideal,) and it also acts as a dining room for the patients from that ward. A very small living room consisting of approximately 90 square feet doubles as a "quiet room" for the speech therapist, a conference room, and a room in which parents are interviewed by the staff. In the narrow corridor leading to the occupational therapy department, which is again approximately one-third of the required size for our in-patient load (again excluding out-patients), one sees two small areas. One is an office which is utilized by the Director of Nursing Services, the visiting consultants, and the Medical Director. It is also the library, the drug cupboard, and a place for storing some of the files. This room has one window only and this is not on an outside wall but opens into the occupational Therapy room. The other small room off this hallway has a floor space of about 115 square feet, and has a small bathroom, and a large room which acts as a storage room for most of the clothing for the children, shelves for linen for the Centre and a cloak room for the staff. This as well has no

teaching has to be done on the ward. The main ward for the older children consists of approximately 1[illegible] square feet and is divided by a curtain down the centre between the boys and girls. During the day it acts as an indoor recreation area, and as a place for the teacher to teach the pupils who cannot fit into the small room. [illegible] space for the speech therapist to visit the patients ([illegible] is to itself is far from ideal,) and it also acts as a dining room for the patients from that ward. A very small living room consisting of approximately 90 square feet doubles as a "quiet room" for the severely [illegible] [illegible] viewed by the staff. In the narrow corridor leading to the occupational therapy department, which is approximately one-third of the required size for our [illegible] patient load (again excluding out-patients), one sees two small areas. One is an office which is utilized by the Director of Nursing Services, the visiting consultant and the Medical Director. It is also the library, the drug cupboard, and a place for storing some of the files. This room has one window only and this is set on an outside wall but opens into the occupational therapy room. The other small room off this hallway has a floor space of about 175 square feet, and has a small bathroom, and

clothing for the children, shelves for linen for the Gastro

outside window. In the neighbourhood another small bathroom exists. The main office has approximately 140 square feet and is occupied by the receptionist who also helps in the maintenance of various aspects of housekeeping, is also occupied by the survey nurse, and by a steno-typist whose work-day from beginning to end is taken up completely with the transcription of dictated correspondence and other clinical material. This room also serves to house the three large filing cabinets in which the records of the Centre are kept. Across from this office is another room of approximately the same size in which there is an electric washer and dryer and in which the laundry is done for the clothing and small sundry items of the Centre. The larger articles are laundered at the Hospital for Mental and Nervous Diseases Laundry, this service being provided through the Provincial Department of Health. There is then a small ramp leading down to a lower level which represents the second wing of the original building called the Hickman Wing. Most of this is taken up by a ward which contains approximately twelve cots and an occasional bed. This ward has a floor space of about 450 square feet. Across the hall is another bathroom and two other small rooms. These rooms each of which have an area of 70 square feet serve as (1) an activities of daily living room, and (2) social service department. For the former of the equipment is very crowded and only one patient can be accommodated at a time. In the social service department there are two desks and many filing cabinets and books. The social worker and another steno-typist occupy this

[illegible]

[illegible]

[illegible]

stenographer, is also occupied by the assistant [illegible] by a steno-typist whose work-day from beginning to end is taken up completely with the transcription of dictation, correspondence and other clerical material. [illegible] time serves to house the three large filing cabinets in which the records of the Centre are kept. Across from this office is another room of approximately the same size in which stands an electric washer and a [illegible] in which the laundry is done for the clothing and [illegible] sundry items of the Centre. The larger articles are laundered at the Hospital for Mental and Nervous Diseases. Laundry, this service being provided through the Prov. Department of Health. There is then a small room leading down to a lower level which represents the second wing of the original building called the Hickson Wing. Most of this is taken up by a ward which contains approximately twelve beds plus an occasional bed. This ward has a floor space of about 400 square feet. [illegible] the hall is another bathroom and two other small rooms. These rooms each of which have an area of 70 square feet serve as (1) an activities of daily living room, and (2) social service department. For the former of the equipment is very crowded and only one patient can be accommodated at a time. In the social service department there are two desks and many filing cabinets and [illegible] the social worker and another steno-typist occupy this

room but one or the other must vacate it periodically for the physiotherapist to do her desk work and filing and completion of case records. Whenever a parent is to be interviewed by the social worker, either the physiotherapist or the steno-typist, whoever is there at that time has to leave the room.

This building is situated on a lot of land which is covered, for the most part by fir and spruce trees, except for the immediate area around the building and for a rather large playground area which has some facilities such as swings, etc. for children's recreation. The ground surface is very rough and even for normal children it is not useful for comfortable playing. A stream runs through the far end of the land and this has been harnessed to form a swimming pool which is a very desirable aspect of the recreational programme. The land itself has recently been rearranged and reconstructed to provide better sewerage facilities. For the previous year theextent of the overflow from the several septic tanks was such that it made the whole atmosphere very unpleasant as well as very unhealthly. It did not appear at first that something could be done but salvage procedure has been carried out and for the time being, at least, the ground will absorb some more waste. However, this in itself, mitigates against the extension of the present building or the erection of a new building.

The water supply comes from an artesian well which was provided within the last five years. The heating plant consists of 2 large furnaces of warm air type, one occupying a place in the physiotherapy de-

the physiotherapist to do her desk work and filing and completion of case records. Whenever a parent is to be [illegible] therapist or the speech-typist, whoever is there at that time has to leave the room.

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The water supply comes from an artesian well which was provided within the last five years. The

partment and the other being situated in the laundry room. Panic doors have been installed recently on all major exits, and a sprinkler system at a cost of over $10,000 was installed within the last four years. There are, however, no provisions for adequate modern disposal of waste and there is not even a bedpan hopper in the Centre. This situation is being corrected possibly within the next few months. Up to the present time, however, disposal of any human excreta which possibly could have contained an infectious virus (for example, infectious jaundice) had to be done by burying the excreta in a hole in the ground away from the Centre. This was the duty of the staff nurses. Sterile equipment at the present time is being provided for through the facilities of the General Hospital in St. John's where the equipment is sterilized and brought out periodically or when needed. Steps have been recently taken to provide an autoclave in the Centre. In the physiotherapy room, the equipment is reasonably good. There is, however, a decided lack of sufficient equipment of every type. Much of the equipment has been provided by the utility staff, this equipment including the examining benches, therapeutic exercise stairs and the patient trolleys and parallel bars. There is a large Hubbard Tank there with a central depression for upright therapy, a new Hydroculator Moist Heat Machine, a new Whirlpool Bath, a special Kanavel Hand Exercise Apparatus, and a new Guthre-Smith Suspension Apparatus. In the occupational therapy department much improvisation has been made, but the equipment is gradually being

and the other being situated in the laundry room. Panic doors have been installed to assist on all major exits, and a sprinkler system at a cost of over $10,000 was installed within the last four years. There are, however, no provisions for adequate modern disposal of waste and there is not even a bedpan burner in the Centre. This situation is being corrected possibly within the next few months. Up to the present time, however, disposal of any human excreta which possibly could have contained an infectious virus (for example, infectious jaundice) had to be done by burying the excreta in a hole in the ground away from the centre. This was the duty of the staff nurses. Sterile equipment at the present time is being provided for through the facilities of the General Hospital in St. John, where the equipment is sterilized and brought out periodically or when needed. Steps have been recently taken to provide an autoclave in the Centre. In the physiotherapy room, the equipment is reasonably good. There is, however, a decided lack of sufficient equipment of every type. Much of the equipment has been provided by the utility itself. This equipment includes the examining benches, therapeutic exercise stains and the patient trolleys and parallel bars. There is a large Hubbard Tank there with a central depression for upright therapy, a new Hydrocollator Moist Heat Machine, a new Whirlpool Bath, a special Manual Hand Exercise Apparatus, and a new Guthrie-Smith Suspension Apparatus. In the occupational therapy department much improvisation has been made, but the equipment is gradually being

brought up to basic standards.

The speech therapy department has no actual place in which to set its feet. The speech therapist at the present time is an elocutionist, who works under the direct supervision of the Department of Health Speech Therapist. There is no special room in which she may work but she does utilize the living room when it is not being used as a conference room or an interview room, and a lot of her work is carried out on the open ward. The amount of equipment which she has to use is very limited and lacks such basic things as a tape recorder. There is, however, a phonograph record player in the occupational therapy department which is of some help to the speech therapist. There is no equipment for audiological evaluation, and such equipment which in the average rehabilitation Centre is considered basic, for example a language-master, is considered at this Centre to be a luxury which may be obtained in the future.

During the latter half of 1960 and for part of 1961 we were fortunate in having four physiotherapists and with our present in-patient load of 31 patients and our daily out-patient load of 15 patients, the work load per therapist was approaching the usually accepted level of 9 patients per therapist per day. However, at the present time there are only two physiotherapists and the work load is correspondingly doubled. The occupational therapy department with its work load of approximately 30 patients a day, is burdened well beyond its limits with only one therapist. Some assistance in occupational therapy is carried on by the activities of daily living

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department, but in a limited capacity only. The number of nurses required for reasonable coverage of the Centre on a twenty-four hour basis would be, ideally, sixteen, but at the present time there are a total of eight graduate nurses and seven practical nurses (ward aides). The social service department is taxed well beyond its capabilities and there should be at least an assistant social worker to assist the present social worker in her many and varied duties. Dental services are provided by a local dentist who receives a small honourariam to defray the costs of materials utilized, but this service in itself leaves much to be desired and it can be safely said that it is obvious that dental care of the in-patients does not reach any ordinary standards in Canada.

The education facilities at the Centre are deplorable, there being only one teacher where at least two are required for the number of patients attending and the space alloted for a schoolroom, 200 square feet, is obviously ridiculous. The suggested space for a Centre of this size would be in the nature of 600 square feet. At least two teachers are required but at the present time the Department of Education can supply only one.

Transportation provides a very unique problem because of the location of the Centre away from St. John's. If the Centre were located in the City, the actual cost of transportation would be immediately decreased by 75%. As well as being a costly part of the operation of the Centre, it also provides a clumsy mechanism where

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patients and staff reach the Centre and of course must be delivered back to their homes. The location of the Centre away from St. John's at the present time provides many other hazards which only too frequently become so serious as to approach the categorization of being disastrous. During the winter time it is not an uncommon practice for the roads to be blocked with snow so that no vehicles can pass and only those personnel who can walk the 7 miles or can get there by skis reach the Centre. At one time within the past two years for a period of a week the Centre was isolated and food shortage was anticipated. The snow plows were not available on this road early after the storm ceased because it is a secondary road and the provision of food supplies was a great problem and arrangements had to be made whereby they could be dropped from the air by helicopter. During the summer time the ever existing danger of forest fires surrounds the area and at least one or two fires occur in the neighbourhood every summer. Fortunately, the Centre has not yet been damaged but there have been several close escapes.

Direct services supplied to the patient include the provision of braces crutches, prescription boots, prosthesis and prothetic appliances, corsets, wheelchairs etc. This Centre does not have a Brace Shop of its own. The only brace making and prothetic facilities in the Province of Newfoundland is through the Prosthetic Services Division of the General Hospital. This is a small service whose lot it is to provide prosthetic appliances, prosthesis, and braces and other associated

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appliances to all parts of Newfoundland. The Newfoundland Society for the Care of Crippled Children and Adults buys its required braces, etc., from this Brace Shop. It can be safely said that the Brace Shop itself as it exists in the General Hospital would be inadequate to provide the Centre for its needs. It consists of a floor space of 1,100 sq. ft., with a considerable lack of equipment due, not to lack of funds, but more to lack of floor space. The Staff consists of one Prothetist who is the Chief Prosthetist, five mechanics, and two leather-and-shoe men. There is also at the present time a receptionist, a student brace man who has completed the 1st part of his course at N.Y.U. and a student prosthetic man. It is estimated that for this service to function properly it would need 7,000 sq. ft. of floor space, much new machinery, and a greatly increased staff including a Chief Prosthetist, a Certified Brace Maker and Certified Prosthetist, eight or nine machinists, three leather and shoe men, a stock clerk and receptionist, a utility man and an orderly. The Brace and Prosthetic Services therefore are very poorly provided for and are in themselves inadequate for the operation of the Centre itself. In addition to supplying the Sunshine Camp Rehabilitation Centre, this Brace Shop provides all services along these lines for the whole of the Province of Newfoundland. This is a deplorable situation and it results in many delays in the provision of treatment for patients. It also lengthens the stay of every patient at the Centre and of course it prolongs the hospital stay of many patients

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in the various city hospitals. The length of period waiting for a brace to be made following the measurements and this means a simple long leg or below knee brace, is anywhere between six and eight weeks. This is really the minimum period and as long as three and a half to four months have elapsed before the necessary appliance has been supplied. In the manufacture of artificial limbs a similar delay is encountered. These delays obviously produce an unnecessary added expenditure on the operation of the Centre but it is the only source from which we can obtain our supplies at the present time.

Prescription boots are obtained by the Rehabilitation Centre from various Canadian Shoe Manufacturers such as Savage Shoe Company. Corsets and wheelchairs are also bought from Canadian Manufacturers, the Ottawa Truss Company being the most commonly patronized source.

From the foregoing it can be seen that there are two very great deficiencies in the rehabilitation services for children in Newfoundland. The first is the obvious lack of a suitably sized Centre and the second is the overwork,and overcrowding, of the present small Centre, which in itself is well below the standards set down for a Centre of its bed capacity by standard Rehabilitation Centre evaluation study groups. In spite of the inadequate facilities the Centre however, is doing a tremendous job in providing the only total rehabilitative services available in Newfoundland at the present time.

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THE RECOMMENDATIONS.

It has been found that for the next five years and operating at a slightly greater rate than we are at the present time we would require a fifty bed Centre of approximately 40,000 sq. ft. It is estimated that after five years this Centre would then become as inadequate as the present one is. Such a Centre at the present time however, would allow us to treat approximately one hundred and fifty Out-Patients a week provided the personnel were available. We would require at least ten and possibly twelve physiotherapists, two or three occupational therapists, two social workers, and corresponding increase in all other Departments. Increased facilities from the point of view of treatment and evaluation will be necessary in such a large Centre. The likelihood of the Newfoundland Society for the Care of Crippled Children and Adults building its own Centre within the very near future to meet these requirements for the next five years, is something which we cannot expect or even hope for. However, the hospital at the former Pepperrell U.S. Air Force Base which has recently been vacated, would provide on the first floor, thirty thousand square feet. Eliminating the Brace Shop and the Kitchen and Dining area which is provided for on the second floor of that building, this thirty thousand square feet would provide us with our immediate needs from the point of view of space. From the point of view of equipment and staff and the necessary increased operating expenditures, these will have to be provided for by an increased per diem rate

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from the Provincial Hospital Insurance Scheme. The decrease in transportation requirements would reduce the expenditure in that direction, but we feel that an increased revenue could come from Federal Grants in the nature of grants for Crippled Children. It is therefore our recommendation that in order to facilitate the procurement of these grants that the Sunshine Camp Children's Rehabilitation Centre in St. John's be recognized as a bona-fide Institution by the Federal Government. In addition this recognition by the Federal Government, would exempt us from Federal Sales T x on Drugs, Printing and Stationery, Equipment and other materials. By this means we would be exempt from Customs duty on certain types of hospital equipment which are dutiable to us but not to the Provincial Government. We feel that since these privileges are afforded the Provincial Department of Health they should also be available to us. At the present time we are exempt from duty and sales tax on crutches, wheelchairs, and some types of mechanical equipment which may be used in the treatment of Polio patients, but this does not apply to most of the essential equipment which we have to purchase.

The Newfoundland Society for the Care of Crippled Children and Adults feels strongly that a more active participation in rehabilitation by the Provincial Government should be exhibited. This can be provided at once by a substantial increase in our per diem rate, or by the provision of payment for outpatient rehabilitation services. At the present time

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the per diem rate obtained from the Provincial Government for In-Patients is now largely absorbed by our present Out-Patient program, which in itself is of necessity large, because of our lack of In-Patient facilities. The existence of such a paradox must first be removed before any concrete steps in improvement of our children's rehabilitation services can be established. From the long term point of view this Society feels that the provision of a fifty bed unit for children alone at the present time would in itself be inadequate in five years time, provided the adult rehabilitation field is not embarked upon to any extent. If however, the adult field is entered upon, and this is necessary and is included in our plans, then the provision of this Centre will be immediately inadequate. However, we feel that such a fifty bed Centre at the present time would be a tremendous help in our rehabilitation program.

This Society feels that if adequate rehabilitation facilities are to be provided in Newfoundland for both children and adults then a two hundred bed unit equally divided between children and adults with provision for about 2 hundred Out-Patients per week, should be made available. We feel that within five years this will be an absolute necessity just as it is absolutely necessary at the present time that our Children's Centre be enlarged to fifty beds.

It is noted that such bodies as the Workmen's Compensation Board of Newfoundland have made little or no visible effort towards the establishment of adequate

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rehabilitation facilities for the injured industrial worker. The lack of such facilities is readily visualized when it is considered that the average injured workman could be back to work in approximately 25% to 30% less time than he is at present with a correspondingly less disability than at present, if the basic required rehabilitation facilities were available. The physicians and their paramedical staff are constantly working at a disadvantage to produce adequate results and to decrease disabilities without these facilities.

From the point of view of provision of staff for such a Centre, either the smaller fifty bed unit visualized for the near future or the larger centre for the not too distant future, this Society feels that there are two main aspects which fall into the province of the Federal Government. The first is a recruitment program to stimulate interest in the various divisions of rehabilitation, and this should be started in high school and early college level, to encourage these younger people to enter these professions, and to provide adequate grants for their training period. Attendent upon these actions of course, will be the provision of facilities in which these people may work. The second main aspect deals with the encouragement for, and the provision of training for medical specialists in physical medicine and rehabilitation. Physiatrists are altogether too few in Canada and at the present time there is not one in Newfoundland. There is a need, this Society feels, for at least two in this

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province and more than likely for three if facilities can be provided for one either in Central Newfoundland or on the West Coast. Certainly for the proper direction of a fifty bed Children's rehabilitation Centre, a full time Physiatrist is required. The provision of adequate grants to encourage young medical graduates to study this specialty, the provision of adequate income for them when they are finished their course, and, most important, the provision of the facilities in which they may work are all absolute necessities to overcome the deplorable lack of rehabilitation services in Newfoundland at the present time.

The Society feels that in St. John's and later possibly in other areas of Newfoundland, there should be an increase in the facilities for Orthopaedic Surgery. This is a small part of a total rehabilitation program, but it is an essential portion of the program and a very important one. The present Orthopaedic facilities in St. John's are located mainly in the General Hospital, and approximately one hundred and ten patients are housed in a previous war time hospital built in 1941. This building which was erected as a five year building is now in its twenty-first year and shows the subsequent deterioration. The facilities in this hospital are entirely inadequzte and up to two years ago did not even have an x-ray machine. There are no operating facilities in this hospital and all patients for surgery have to be transported to the General Hospital. In short the Orthopaedic facilities are entirely inadequate at the present time and it is

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estimated that the provision of two hundred and fifty Orthopaedic beds in an adequate building with adequate facilities would provide the necessary service. This number, of course, need not be as high as two hundred and fifty if adequate convalescent facilities were available.

This Society would like to recommend that the prosthetic and brace aspect of the rehabilitation services be improved immediately. At the present time these facilities are provided through the Provincial Government, and, as a very large percentage of these facilities are utilized by private agencies such as the Dept. of Veterans Affairs, Workmen's Compensation Board, the Sunshine Camp Children's Rehabilitation Centre, it would appear reasonable to assume that a privately operated Brace and Prosthetic shop would have no difficulty in establishing in St. John's. Either the establishment of such a concern, or the enlargement of the present facilities would solve the problem and on the basis of that the Provincial Government should be encouraged to take the necessary steps in that direction.

The Nfld. Society for the Care of Crippled Children and Adults also feel that the provision of suitable institutions for totally disabled children should be provided for in St. John's and, possibly in Central and Western Newfoundland. The local outport situation in Newfoundland makes it practically impossible for a child to carry on with his home program no matter how well instructed and ambitious he is while

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at the Rehabilitation Centre. For the greater part of the year while these children should be attending school they would be far better housed in a suitable building which provides as well as ordinary living comforts and food, a school. The Society feels that an increased case finding program is also essential for finding these patients and bringing them in for treatment. A considerable reluctance on the part of people living in outlying districts prevents them from coming in for treatment and they must be found and encouraged to come in.

The provision of work shops as a part of the rehabilitation program as a step towards re-training of personnel is an essential aspect of a rehabilitation program and this Society feels that this should be considered in any rehabilitation Centre. We also feel and would like to recommend that such bodies as the Department of Veterans Affairs in Newfoundland, the Workmen's Compensation Board in Newfoundland, should take a more active interest and participation in the provision of rehabilitation for their patients. In Newfoundland at the present time the adult rehabilitation program consists of a case finding program with training provided in some cases only We feel that the adult field has not yet been touched from the point of view of the provision of rehabilitation services, and we are making a strong recommendation that all possible avenues to overcome this deficiency within the next few years, be made.

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The Provincial Government, has, over the past

two years shown its interest in Rehabilitation by sponsoring the Nfld. Rehabilitation Council, a body which is in the process of organization and investigation. An excellent conference on Rehabilitation was sponsored by the Premier of Newfoundland in October 1960, and much valuable information was gained. While we recognize that these steps are very necessary and very important, we cannot help but feel that, the great need for rehabilitation services as we see it every day, should be eliminated at once by more definite action.

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DR. SHAPTER: Mr. Chairman, and members of the Royal Commission. You have our brief, and our attempt at a summary of the main points of the brief, and I will attempt now to summarize our summary very briefly, and put our points forth.

Sir, we have attempted to present this brief with an emphasis on our needs for children's rehabilitation in Newfoundland, but we hope that we have given you an outline of the needs for adults' rehabilitation in our province. Our society, which is known as the Newfoundland Society for the Care of Cripped Children and Adults, is a voluntary organization, and this organization acts as the Board of Directors and the Board of Governors for the Sunshine Camp Children's Rehabilitation Centre. This is the only rehabilitation centre, the only place in Newfoundland where total rehabilitation services are provided. Our services are broad and comprehensive, and they include all the aspects of a modern rehab centre, but our facilities are very lacking. We have no space, and our building is very useless from the point of view of expansion. We have made great strides since 1958 to 1961. We are now at a stand still, again because of the lack of facilities. We have been able to operate our centre financially through the provincial hospital insurance plan, plus some federal health grants, and also by funds raised through our campaign. This year it appears that we will not raise enough money to operate, and this is on the projected budget ending March 1962.

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Sir, we have attempted to present this brief with an emphasis on our needs for children's [illegible] in our province. Our society, which is known as the Newfoundland Society for the Care of Crippled Children and Adults, is a voluntary organization, and this organization acts as the Board of Directors and the Board of Governors [illegible].

This is the only rehabilitation centre, the only place in Newfoundland where total rehabilitation services are provided. Our services are broad and comprehensive. They include all the aspects of a modern rehab centre. But our facilities are very lacking. We have no space, and our building is very useless from the point of view of expansion. We have made great strides since 1958 to 1961. We are now at a stand still, again because of the lack of facilities. We have been able to operate our centre financially through the provincial hospital insurance plan plus some federal health grants and also by funds raised through our campaign. This year it appears that we will not raise enough money to operate, and this is on the [illegible] budget [illegible] 1962.

From the point of view of the needs for [illegible]itation services for children only in Newfound[illegible]

our 31-bed centre is not nearly large enough, but considering the method on which we operate and our staff, we feel that a 50-bed centre obtained at the present time would solve many of our problems, and in the brief we have pointed out the means by which this could be obtained at once. This is a short-term, immediate requirement.

We have outlined in the brief as well as in a more or less long-term, five-year requirement, to include adults and children, a plan which must be started now if in five years time we are to see it in operation. We feel that the provincial government, and such bodies as D.V.A., and Workmen's Compensation, would help, and should help in promoting this plan.

We feel also that as well as the projected larger centre, we need many other ancillary buildings, or institutions, mainly because of the geographical outlay of Newfoundland, our crippled children cannot get to school from their home. We need a boarding and a day school for crippled children associated with the centre, and near the centre, so that their treatment can be carried out throughout the year. We need better orthopaedic facilities as part of our total rehabilitation programme. We need workshops for training personnel. There are many other requirements to operate a rehabilitation unit for this province, and we feel that in our brief we have pointed out the means by which this could be obtained now, and could be obtained in the future, the future being a projection so that it will be operating within five years.

COMMISSIONER STRACHAN: What progress has been made towards the accommodation for the hospital, what

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this province, and we feel that in our brief we have

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will be operating within five years.

COMMISSIONER STRACHAN: What progress has

are the buyers?

DR. SHAPTER: We have made our needs known to the provincial Department of Health, but there is no decision yet as to the ownership of the area, and apparently until such is decided the allotment of buildings cannot be brought about. We feel, however, that whether the province is the tenant or the landlord, it does not make any difference, as the building is in St. John's, and the need is obvious.

COMMISSIONER STRACHAN: Have you had hopeful consideration?

DR. SHAPTER: Yes sir, I would say we have had hopeful consideration.

THE CHAIRMAN: Is there anything else you can do? I mean to say, your suggestion is by way of information to the Commission, but can you make any suggestion of a way by which the Commission can help you?

DR. SHAPTER: No sir, this is a very short-term idea, and possibly it can be sold by the time the Commission has their report drawn up, but it was to outline our present programme, but the main plan for the larger centre to be started and arranged for now, to be operating within five years, was the point we wanted to make more obviously.

THE CHAIRMAN: You suggest that one of your needs is a residence, some kind of residential building for those from outside who might come to your rehabilitation centre for services?

DR. SHAPTER: That is right sir, yes.

THE CHAIRMAN: Do you think you have no other

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COMMISSIONER STRACHAN: Have you had

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DR. SHAFTER: Yes sir, I would say we have

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DR. SHAFTER: That is right sir, yes.

THE CHAIRMAN: Do you think you have m

way of getting that, except through additional governmental money?

DR. SHAPTER: That is right sir, we have no way of doing that. We are now running in the red from the point of view of operating expenses. There is no chance that the Society, with its present income, being able to do anything other than trying to maintain our present facilities, which are very inadequate.

THE CHAIRMAN: Perhaps you might tell me if you can. Does the Junior Red Cross operate extensively in this province?

DR. SHAPTER: Yes sir, the Junior Red Cross does operate, and they have been very generous to us. They supplied us over a year ago with twenty wheelchairs for our centre, and recently they supplied us with a new bus for transportation to our centre. This was a gift of the Junior Red Cross. That got us off the hook this year.

THE CHAIRMAN: I don't know whether you are aware that certain provinces, one province in particular, have asked the Junior Red Cross to pilot this project of a residential centre adjacent to a rehabilitation centre?

DR. SHAPTER: Sir, I think it would be, if we moved into the Pepperrell Hospital, if there are schools and buildings next to Pepperrell Hospital which are ideally suited for such a school, it was suggested that the Junior Red Cross would help operate it, but from the point of view of building it --

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you are a voluntary organization. The proposals are being put forward that the government, at either the Ottawa level or the provincial level, or both, should undertake a comprehensive medical care plan. Are you in the position to give consideration to what will be the role of the voluntary agencies such as yours in the event that some such programme should come into being?

DR. SHAPTER: Sir, I can express an opinion. I think that the maintenance of the voluntary body is essential for the operation for such a rehabilitation centre. I think that if there were a comprehensive medical plan sponsored either by insurance or total taxation, still I think that the voluntary bodies should have a part in the operation and control of rehabilitation.

THE CHAIRMAN: And you would have to get your finances from voluntary contributions?

DR. SHAPTER: Partly sir, yes.

THE CHAIRMAN: Have you any view on this, that if a comprehensive programme was put in, financed either wholly by the State or partly by the State and other contributions, what reaction will there be on the part of the public to voluntary donations, when the State, in one form or another, has assumed full control of health services?

DR. SHAPTER: Well, sir, in Great Britain the situation still exists, but people still have to buy wheelchairs and other equipment for themselves, and the voluntary contributions from the public will still be necessary to obtain for us the equipment for which I don't think even in Canada a comprehensive prepaid medical plan

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would provide.

THE CHAIRMAN: Assuming that would be necessary, would those contributions be forthcoming once it is decided that the government, at whatever level it would be, have accepted the full responsibility for health services?

DR. SHAPTER: It would be a little more difficult, sir, than it is now. But the crippled child has an appeal, the parents of crippled children always feel, and friends, and people associated with the plan, I don't think would let the fact that the government are paying most of the shot interfere with the fact thatwe need more. I still think there would be a place for voluntary contributions from the public, and I think they would be collected as we are doing now.

COMMISSIONER VAN WART: I notice that your work is divided between crippled children and adults. Is the majority of your work with crippled children or with the rehabilitation of adults?

DR. SHAPTER: Sir, our work is nearly all children. We have taken an age of about 16 or 17 as the maximum age, but because there are no adult's facilities, many of our children are going over that age, but we still keep them on to give them the treatment which they need. We do contribute a little to the adult field by providing such things as correspondence courses and equipment to help train the adults, but we cannot go beyond the children's level, but we intend to enter some day into adult rehab.

COMMISSIONER VAN WART: The patients are not referred to your centre for rehabilitation, the adults,

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are they?

DR. SHAPTER: No sir.

COMMISSIONER VAN WART: You have no relations with the Compensation Board?

DR. SHAPTER: No sir.

COMMISSIONER VAN WART: And no relations with hospitals for referrals for rehabilitation?

DR. SHAPTER: For adults, no sir.

COMMISSIONER VAN WART: Just not apropos to your brief exactly, but for my own information, what is the percentage of the population of St. John's towards the whole population of Newfoundland? What is the fraction roughly?

DR. SHAPTER: About 20%.

COMMISSIONER VAN WART: And you serve that district of 20% practically, that is all your work, do they come in from all over?

DR. SHAPTER: We serve 100%.

COMMISSIONER VAN WART: But you are not getting very many from outside, are you?

DR. SHAPTER: Oh, yes we are sir. We have a very active social service programme, and the areas are visited, and we have travelling clinics.

COMMISSIONER VAN WART: Your travelling clinics are headed by an orthopaedic surgeon, or by nurses?

DR. SHAPTER: The whole team goes, the orthopaedic surgeon and/or the neurologist, the physiotherapist, occupational therapist, activities of living therapist, the director of nurses, social services, speech service.

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COMMISSIONER VAN WART: Your travelling

DR. SHAFTER: The nurse team goes, the

COMMISSIONER VAN WART: You say an orthopaedist travels with it. Does your organization pay him for his services, or does someone else pay?

DR. SHAPTER: For the clinic sir?

COMMISSIONER VAN WART: Yes, for his travelling when he is away?

DR. SHAPTER: Nobody pays.

COMMISSIONER VAN WART: It is entirely voluntary on his part?

DR. SHAPTER: Yes.

COMMISSIONER McCUTCHEON: I take it that you are not satisfied that even a comprehensive health care scheme will ever be comprehensive enough to eliminate the necessity for the initiative and innovation and so on that has been given in this whole field by the voluntary health agencies up to date?

DR. SHAPTER: That is right sir. I feel that the cold bureaucracy of any government cannot reach the needs for the individual crippled or disabled person.

COMMISSIONER McCUTCHEON: And that might apply in other fields as well?

DR. SHAPTER: That is right sir.

THE CHAIRMAN: This may have been covered before, and I want to ask Dr. McGrath, if you might. Rehabilitation, insofar as the Workmen's Compensation Board is concerned, of adults. Are you able to say how that is handled, Doctor?

DR. McGRATH: Well, I think as far as I know, the Workmen's Compensation Board has no limit on its activity, and as far as possible they attempt to bring

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a man back to what his pre-injury condition was. In the cases where that is not possible, I don't know what happens after that -- whether he is continued on financial assistance or not.

THE CHAIRMAN: No, I am not concerned about that. I am concerned with whether the other phase has been -- the physical rehabilitation.

DR. McGRATH: What can be done in Newfoundland is done here, but men are sent to other large centres, such as Montreal and Toronto, for conditions that can only be handled in a large centre. I don't think there is any limitation on what the Board is prepared to do for the individual. I think Dr. Shapter will be aware of that: These cases are sent away because of the special type of treatment that cannot be done here. I know of some cases.

DR. SHAPTER: There are a few cases I know have been sent on the recommendation either of the Board or of the attending physician. From the point of view of the Workmen's Compensation Board and our rehabilitation services, I think I can state categorically that they are pretty well absent -- the rehabilitation basically requires for an injured workman a physiotherapist, and unless the person is an in-patient at a hospital or at the Sunshine Camp, or unless he is young enough and can be an out-patient at the Sunshine Camp, we have sent them because there is no place in this province where any person can receive physiotherapy at the hands of a chartered physiotherapist. There is not one chartered physiotherapist available to a person outside the hospital, and you must be an in-patient

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to get it. If physiotherapy, the basis of rehabilitation, is absent you have not started.

DR. McGRATH: I wasn't suggesting that. The physiotherapist services here are extremely limited. Even in the hospital we don't have anything, and there is no provision existing outside.

THE CHAIRMAN: It is just one more of these acknowledged deficiencies?

DR. McGRATH: Quite definitely.

COMMISSIONER McCUTCHEON: Is that a deficiency which may be more economically disposed of and more readily disposed of if it was to be done on a joint effort of the four Atlantic provinces than if each province attempted to do it?

DR. McGRATH: That is conceivable, but they are short too. We do have a committee on the four Atlantic provinces to discuss and deal with that type of problem, but again it is just as it is with nurses and doctors: We have training schemes for physiotherapists, but there are not enough people. Perhaps we are not paying enough -- any of us. However, there is a limitation to that. We can't go into competition with the other provinces as to what we do. Quite recently we raised the pay in Newfoundland to make it about equal to the other Atlantic provinces. If money is to be the answer to any problem, there is no service you can't get if you are prepared to ignore the money problem altogether, but in practise, as you know, you cannot do that. At the present time it doesn't seem to me enough people are being attracted into physiotherapy to provide those that are

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necessary. There may not be sufficient training centres, but even as the thing stands, I don't think there are any great barriers in the way of anyone who wants to go into physiotherapy, and I think the reason is we are not attracting them.

COMMISSIONER McCUTCHEON: I am thinking both of the physical facilities as well as the personnel required, and I was thinking of the Workmen's Compensation rehabilitation centre in Toronto which serves a population of six million people, because they haven't got them spotted all over, although northern Ontario frequently suggests it should secede from southern Ontario and have similar facilities itself. I am wondering if it is not a more practical and realistic situation to think of one well-equipped well-staffed rehabilitation centre in the Atlantic provinces, than one in Charlottetown and one in St. John's and so on?

DR. McGRATH: You mean the actual treatment centre and not the training centre?

COMMISSIONER McCUTCHEON: Yes.

DR. McGRATH: I don't think I have an opinion on that because I don't think I have considered it a possibility, but it may be well worth considering and looking into. There are difficulties, but they would not be insuperable.

COMMISSIONER McCUTCHEON: If you send people now to Toronto and Montreal, then I would not think the difficulties would be insuperable.

DR. SHAPTER: Mr. Chairman, I don't think that a large centre situated somewhere in the Atlantic

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provinces would be the answer. Rather I think a larger centre in St. John's and one in central Newfoundland and one in Western Newfoundland, and the same situation in the other provinces, would be better because I think the rehabilitation centres should not be just Workmen's Compensation centres. I think the whole programme should be centralized per area in the province rather than one area away from the attending physician who then has to send the patient away and he loses complete contact with the patient. I think it is essential we have our rehabilitation facilities for injured workmen and all other people requiring it in accessible areas.

COMMISSIONER McCUTCHEON: Would you still feel that even though that might take a much longer time to accomplish than central facilities to which people could be referred from different areas?

DR. SHAPTER: If it were a matter of time, it would depend upon the length of time. I don't think it would be much different in time in obtaining one large centre for the Atlantic provinces than it would in obtaining smaller ones.

COMMISSIONER VAN WART: Rehabilitation of adults is a different problem from the handling of crippled children. I can see you have a centre where people could take compensation cases and so on, but that would not meet your treatment of the children, would it?

DR. SHAPTER: No, sir.

COMMISSIONER FIRESTONE: Dr. Shapter, on page 15, the last paragraph, you indicate that you would require a 50-bed centre: Could you tell the Commission how

centre in St. John's and one in central Newfoundland and one in western Newfoundland, and the same situation in the other provinces, would be better because I think the rehabilitation centres should not be just Workmen's [illegible] be centralized perhaps in the province rather than one area away from the attending physician who often has to send the patient away and he loses complete contact with the patient. I think it is essential we have our rehabilitation facilities for injured workmen and all other people requiring it in accessible areas.

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COMMISSIONER FERGUSON: Or, another, or

much it would cost to build such a centre and equip it, and where, in your opinion, the money would come from? If you are not in a position to give us the figures now, could you let us have this information at a later date in writing?

DR. SHAPTER: Sir, I may give you a rough outline of the figures. To build a 50-bed centre, and starting from the ground up, would cost in the nature of $1 million.

COMMISSIONER FIRESTONE: Built and equipped?

DR. SHAPTER: To equip it, sir, would cost a little more depending on the amount of equipment you have. I think we could add another $200,000.00 to that. This is not a guess; this is something we were working on for three years.

COMMISSIONER FIRESTONE: So it would be 1.2 million to build and equip, and where would the money come from, according to your proposals? Would you prefer to take that under advisement and let us know? Have you any proposals to make?

DR. SHAPTER: May I refer the answer to that to Mr. Ewing?

MR. EWING: I think, Mr. Firestone, grants available from both the provincial government and federal government, which I believe in this particular case of $1 million outlay would be approximately $440,000., and we have given consideration to various ways and means, and with provincial government support we thought we may be able to retire any indebtedness incurred over the years by voluntary subscriptions. We raise approximately $70,000.

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a year voluntarily, and these things have been considered for the last couple of years and we have had full and sympathetic hearings from the Department of Health but we have paused to find out what the position would be at Pepperrell.

COMMISSIONER FIRESTONE: Have you not also been saying that you are encountering an operating deficit?

MR. EWING: At present we are.

COMMISSIONER FIRESTONE: Well now, if you are encountering an operating deficit at present, and presumably also in the foreseeable future provided you want to continue with the services you render, would it not become increasingly difficult to finance the operations when you also have to retire borrowings required to build this particular institution for facilities that you are planning to build?

MR. EWING: That is quite right, but the per diem rate at the present time is quite low and it is subject to annual negotiation with the Department of Health and it has been raised progressively each year in the last three years. The deficit at present is not very serious. We do have some funds on hand which will provide services under the Department.

COMMISSIONER FIRESTONE: Would you require in the future an increased grant from government to cover your budget?

MR.EWING: Not on the present operations. I would say we can, with a slight increase in the per diem rate, operate on our present income.

COMMISSIONER FIRESTONE: Are you interested

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[illegible] a last couple of years and we have had full and [illegible] hospitalic hearings from the Department of Health but we [illegible]

[illegible]

COMMISSIONER FIRESTONE: Have you not also been saying that you are encountering an operating [illegible]

MR. EWING: At present we are.

COMMISSIONER FIRESTONE: Well now, if you are encountering an operating deficit at present, and presumably also in the foreseeable future unless you want to continue with the services you render, would it not become increasingly difficult to finance the operation [illegible] this particular institution for facilities that you are planning to build?

MR. EWING: That is quite right, but the per diem rate at the present time is quite low and it is subject to annual negotiation with the Department of Health and it has been raised progressively each year in the last three years. The deficit at present is not very serious. We do have some funds on hand which will provide services [illegible]

[illegible] in the future an increased grant from government to cover your budget?

MR. EWING: Not on the present operations. I would say we can, with a slight increase in the per diem rate, operate on our present income.

COMMISSIONER FIRESTONE: Are you interested

in expanding your services?

MR. EWING: Very much so.

COMMISSIONER FIRESTONE: And how can you do so without an increased grant from government?

MR. EWING: We can't, sir.

COMMISSIONER FIRESTONE: You cannot. Thank you very much.

THE CHAIRMAN: Thank you very much, gentlemen. Perhaps I might on behalf of the Commission say this, that whereas we have heard of many deficiencies in various fields, this becomes quite obvious and very heartening that there are no deficiencies in the big-hearted men and women who are willing to staff these voluntary organizations and do this humanitarian work. Thank you very much.

We will now hear from the Newfoundland Tuberculosis Association.

---EXHIBIT NO. 27: Brief of the Newfoundland Tuberculosis Association.

SUBMISSION OF

THE NEWFOUNDLAND TUBERCULOSIS ASSOCIATION

APPEARANCES: Mr. W. H. Davis, Executive Secretary

Mr. Edgar G. House, Director of Rehabilitation

MR. DAVIS: Mr. Chairman, I have been authorized by the Newfoundland Tuberculosis Association to submit the following statement in support of the case for the inclusion of the cost of sanitorium treatment in the

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Director of Rehabilitation

[illegible]

Authorized by the Newfoundland Tuberculosis Association to submit the following statement in support of the case for the inclusion of the cost of sanatorium treatment in the

federal-provincial hospital insurance programme.

INTRODUCTION: The Newfoundland Tuberculosis Association is a voluntary health agency, which is incorporated under the Companies' Act. It was established in 1944 for the purpose of conducting an educational campaign for the prevention of tuberculosis and for the promotion of health. It assists the provincial health department in case-finding, health education and rehabilitation programmes.

Since the association was formed it has continued to receive financial, moral and working support from all organizations, citizen groups, and individuals throughout the province.

BACKGROUND: Tuberculosis is still the major public health problem in Newfoundland. The disease last year was responsible for the hospitalization of over a thousand patients. Despite tremendous gains in recent years, the dimensions of Newfoundland's tuberculosis problem exceed in every particular those of the other provinces of Canada.

POINT OF VIEW: The Newfoundland Tuberculosis Association expresses the view that the cost of sanitorium or hospital treatment for tuberculosis should be recognized as part of the federal-provincial Hospital Insurance Programme.

SUPPORTING ARGUMENTS: 1. Tuberculosis, because of its communicability, is a national health problem. It is not localized to either community or province, but spreads with the carrier wherever he travels within the nation. A person with undetected active

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Association experience the view that the cost of sanitorium or hospital treatment for tuberculosis should be recognized as part of the Federal-Provincial Hospital Insurance Programme.

SUPPORTING ARGUMENTS: 1. Tuberculosis, because of its communicability, is a national health problem. It is not localized to either community or

tuberculosis living in Vancouver is quite capable of spreading, during his travels, infection in St. John's, or vice versa. Since tuberculosis is a national health problem, the cost of sanitorium treatment should be borne under the federal-provincial hospital insurance programme.

2. The cost of treating tuberculosis is becoming increasingly difficult for the province to bear. Actually the cost of treatment has at least doubled since 1950.

3. Tuberculosis can no longer be regarded as a long term illness, hence it should be treated in the same financial category as other respiratory diseases. In 1950, the average length of stay for a patient in the sanitorium was eighteen months to two years. In 1960 the average length of stay was eight to nine months.

4. Newfoundland, the province that has the most tuberculosis can least afford to pay for the full cost of sanitorium treatment.

5. Tuberculosis is one of the few communicable diseases, that has not been brought under control in Canada.

THE CHAIRMAN: Thank you, Mr. Davis.

COMMISSIONER McCUTCHEON: I assume the reason for the cost of treatment doubling since 1950 is that there has been a more active programme during the last ten years than there may have been prior to that?

MR. DAVIS: This is the pattern, I think, across the nation. One institution reports that a figure - I think it is $4.95 in 1949 per patient day, and in 1961, $11.82.

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COMMISSIONER McCUTCHEON: Are you referring to per patient day cost here or to the overall cost?

MR. DAVIS: Per patient day cost.

COMMISSIONER VAN WART: The modern treatment by drug therapy is more costly than the old treatment, isn't it?

MR. DAVIS: In the old days there were no drugs at all, of course. I think if I may elaborate there, possibly the increase in the cost of treatment is due to the general cost of living. Medical attention is costing more; salaries are higher, and all the other factors that enter into it.

THE CHAIRMAN: Mr. Davis, how is the problem of detection handled in Newfoundland?

MR. DAVIS: Well, first of all, a great source of the discovery of tuberculosis is through the practise of private physicians. They readily refer a suspect to the central clinic for examination, and the Newfoundland Tuberculosis Association operates a floating x-ray clinic -- a ship -- around the coast of Newfoundland and Labrador. That is a source of detecting the early cases, and of course, the Department of Health itself carries out survey work, and we work together as a team -- the Tuberculosis Association and the Department in mass surveys. I think our mass survey programme compares favourably with any programme in any other province.

THE CHAIRMAN: Have you been able to have a survey of the entire population at any one time -- that is, the chest x-ray and so forth?

MR. DAVIS: Yes, I think it is fair to say

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THE CHAIRMAN: Have you been able to have a survey of the entire population at any one time -- that is, the chest x-ray and so forth?

MR. DAVIS: Yes, I think it is fair to say

nearly everybody has at least at one time or another received a chest x-ray. Because of the distribution of our population it is not possible to do a complete survey of the province in any one year, and I don't think that is done anywhere in Canada, but as far as the motor vessel Christmas Seal is concerned, it has made a complete tour of the province at least four times. In the larger areas the surveys are done by mobile units.

THE CHAIRMAN: What has been the contribution of your association to that?

MR. DAVIS: Well, we have carried out an extensive educational programme. We have conducted our surveys with the help of these units, but the main programme, of course, is operated by the Department of Health.

THE CHAIRMAN: You mean the financing is from the Department of Health?

MR. DAVIS: Not our seaborne unit; that is operated almost entirely by the sale of Christmas seal funds.

THE CHAIRMAN: What more do you think could be done in the immediate future initially to detect, because that is, I suppose, the first requirement?

MR. DAVIS: Well, I think we have to look at the problem from a Canadian point of view, from the whole of Canada, as we see it. Canada today has not met the minimum standards set by the World Health Organization in tuberculosis control. There is no province in Canada that has met this standard and, of course, we in Newfoundland are much behind that programme. We feel tuberculosis

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should be looked upon as a national health problem and as such the full cost of treatment should come under the federal-provincial programme.

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THE CHAIRMAN: What do you mean by the World Health Organization standard? We hear reports that in certain provinces of Canada the death rate from tuberculosis is perhaps the lowest in the world, and you say none of the provinces come up to the World Health standard.

MR. DAVIS: That is a correct statement, sir. The World Health Organization states that T.B. can be controlled, although not wiped out, when less than 5% of the children of school leaving age are positive to the tuberculin test. There is no reason we can't regard it as a national health problem.

THE CHAIRMAN: Isn't that the situation in most provinces of Canada today?

MR. DAVIS: No --

THE CHAIRMAN: Certainly in a number of them?

MR. DAVIS: We have been misled greatly by the falling death rates. The rapid fall in death rates has been the yardstick of measuring tuberculosis by the general public, shall we say, but the number of people who are still being admitted to our institutions is still considered very high. I think we have to bear in mind it is a communicable disease, it is an infection. This disease last year sent over 10,000 Canadians to their beds for the first time, over 4,000 other Canadians went there for the second or third time. Any disease that takes that toll of the nation's health should be considered as a national health problem.

COMMISSIONER BALTZAN: Mr. Davis, has it been found that the hospital stay of tuberculosis patients in Newfoundland has been shortened in recent times?

MR. DAVIS: There is a current measure, sir. The World Health Organization states that T.B. can be controlled, although not wiped out, when less than 5% of the children of school leaving age are positive to the tuberculin test. There is no reason we can't regard it as a national health problem.

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COMMISSIONER BARTRAM: Mr. Davis, has it

MR. DAVIS: The length of stay here, according to the Dominion Bureau of Statistics -- all the statistics that I quote are from the Dominion Bureau --

COMMISSIONER BALTZAN: And for Newfoundland?

MR. DAVIS: Yes, that is right. The mean hospital stay in 1950 in this province was 538 days. In 1959, the last year for which statistics are available, the mean stay was 255 days.

COMMISSIONER BALTZAN: There is a remarkable decrease in Newfoundland?

MR. DAVIS: Yes.

COMMISSIONER BALTZAN: Again referring to Newfoundland, have the requirements lessened for bed treatment?

MR. DAVIS: Yes, I would say so. But I think that would be a matter for the Minister.

DR. McGRATH: Yes, we have been closing up our sanitoriums. I think we have closed half of the sanitorium beds.

DR. MILLER: 350 beds closed.

COMMISSIONER BALTZAN: By the same token, would one consider that the incidence is decreasing rather then increasing?

MR. DAVIS: There is an indication that the incidence is decreasing. The death rate is decreasing rapidly, but it is not decreasing as much as it should really. The ratio of decline in Newfoundland is much higher than in other provinces of Canada, mainly because we had a lot of tuberculosis before we started the programme.

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COMMISSIONER BAITZMAN: And for Newfoundland?

MR. DAVIS: Yes, that is right. The mean hospital stay in 1950 in this province was 538 days. In 1950, the last year for which statistics are available, the mean stay was 295 days.

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DR. McGRATH: I think the situation is that the incidence of tuberculosis, as far as we know, has not declined as rapidly as the death rate. The death rate decline has been phenomenal, but I am sure we can't assert that the incidence has declined in proportion.

COMMISSIONER BALTZAN: But as far as infection is concern, it has declined?

DR. McGRATH: That is right. But it hasn't declined as rapidly as the death rate. But the incidence of infection is not declining at the same rate.

COMMISSIONER BALTZAN: In other words, the treatment is better than prevention today.

DR. McGRATH: I am not sure what you mean. We were successful with the treatment.

DR. MILLER: It is not better, it is more effective.

COMMISSIONER GIRARD: To what extent has v.c.g. vaccination been used?

MR. DAVIS: Newfoundland has done more v.c.g. vaccinations on a per capita basis than any other province in Canada. The total figure, the total number of children who have been vaccinated, as distinct from those who have been examined, now stands at 154,000 at the end of 1960, which represents about 33% of the total population. I doubt if there is any other part of the world where there has been more extensive v.c.g. vaccination carried out. This has been a most effective programme, which has been done mainly by the nurses of the Department of Health; the Tuberculosis Association has been co-operating in making the facilities available, in the isolated areas, an

DR. MORRATH: I think the situation is that [illegible]

[illegible]

that the incidence has declined in proportion.

COMMISSIONER BAILEY: But as to the situation in Canada, it has declined?

DR. MORRATH: That is right. But it has declined as rapidly as the death rate. But the incidence of infection is not declining at the same rate.

COMMISSIONER BAILEY: In other words, the treatment is better than prevention today.

DR. MORRATH: I am not sure what you mean. We were successful with the treatment.

DR. MILLER: It is not better, it is more [illegible]

COMMISSIONER GIRARD: To what extent has v.o.g. vaccination been used?

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the Tuberculosis Association has been co-operating in making the facilities available, in the isolated areas, and

so on.

COMMISSIONER GIRARD: Is your goal 100%?

MR. DAVIS: I would almost hazard a guess that it is in the group under 21. The vaccine is given usually in infancy and young people up to 15 years of age; and I think the Minister mentioned yesterday morning the rapid decline of tuberculosis and meningitis in which v.c.g. has made a great contribution.

COMMISSIONER FIRESTONE: Mr. Chairman, it has been presented to us that Newfoundland has the greatest incidence of tuberculosis and that Newfoundland is a province which can least afford to pay for the treatment; and it has also been said that it is still a national problem which still has not been brought under control, particularly in Newfoundland. Would it be possible for the Newfoundland Tuberculosis Association to let the Commission know in a subsequent submission what in its opinion would be the facilities required and the personnel required to bring tuberculosis in Newfoundland under substantial control. I emphasize the words "substantial control"; we can't be all perfect at all times. And we would like to know your views as to what would be involved financially in developing such a realistic and practical programme, and where in your opinion the money should come from to pay for such a programme.

MR. DAVIS: Yes. Would you prefer to have that later in writing?

COMMISSIONER FIRESTONE: If it is acceptable to you.

MR. DAVIS: Yes, we shall do that.

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COMMISSIONER FIRESTONE: If it is presented to you.

MR. DAVIS: Yes, we shall do that.

THE CHAIRMAN: Thank you very much, Mr. Davis and Mr. House. The remarks made to the preceding group apply equally to the Newfoundland Tuberculosis Association and to the voluntary workers in it.

The next submission will be from the Registered Nurses of Newfoundland.

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SUBMISSION OF

THE REGISTERED NURSES OF NEWFOUNDLAND

---EXHIBIT NO. 28: Submission of the Registered Nurses of Newfoundland.

APPEARANCES: Miss Sommers

Miss Lewis

Miss Laracy

Sister Calasantius

MISS LEWIS: Mr. Chairman, members of the Commission, before presenting this brief I would like to introduce my colleagues here. On my extreme left, Sister Calasantius, the second vice-president. Next Miss Laracy, the Executive Secretary of the Association, and on my right Miss Sommers, a past president of the Association, and I am Miss Lewis, president.

Commission, before presenting this brief I would like to introduce my colleague here. On my extreme left, Sister Gilsenting, the second vice-president. Next Miss Lewis the Executive Secretary of the Association, and on my right Miss Sommers, a past president of the association, and I am Miss Lewis, president.

SUMMARY

A. Newfoundland has three schools of nursing. Approximately one hundred and forty nurses graduate per year.

Due to the isolation of many of the small communities the provision for nursing services in these areas is a very difficult problem. This isolation does not tend to attract sufficient nurses to ease the shortage.

It is recognized also that lack of social life and transportation in most of the Cottage Hospital areas are other factors in the Chronic shortage.

Of the nine hundred and ninety nurses registered with the Association for the Year 1960, approximately six hundred and sixty one of these are in St. John's, the remainder are scattered over the rest of the island.

A statistical survey of all inactive nurses in Newfoundland has been carried out under the direction of the Association.

Consideration is being given to the possibility of legislation for nursing assistants.

The Association has given consideration to these problems and the following statements and recommendations are presented in support of this.

B. RECOMMENDATIONS

1. That as the shortage of nurses in Cottage Hospitals is a chronic condition, it is recommended that an affiliation programme for senior student nurses in Cottage Hospitals under super-

Due to the isolation of many of the small communities the provision for nursing services in these areas is a very difficult problem. This isolation does not tend to attract sufficient nurses to ease the shortage.

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A statistical survey of all inactive nurses in Newfoundland has been carried out under the directory of the Association.

Consideration is being given to the possibility of legislation for nursing assistants.

The Association has given consideration to amendments are presented in support of this.

vision be established, as we believe this would be a factor in the stimulation of the recruitment of registered nurses for Cottage Hospital areas.

11. That before any plans for the setting up of future schools of nursing are formulated the Association of Registered Nurses of Newfoundland should be consulted.

111. That in any future planning for the training of Nursing Assistants the Association of Registered Nurses of Newfoundland give leadership in this area, and that specific plans be prepared to improve and possibly expand the functions of this group.

1V. That we believe a University School of Nursing both on a post-graduate and an under-graduate level is essential to meet the future needs of this province.

C. 1. THE ASSOCIATION

The Association of Registered Nurses of Newfoundland was incorporated under an Act of Parliament on May 20th, 1953, and came into force on January 1st, 1954.

OBJECTIVES

(a) to dignify the profession by maintaining and improving the ethical and professional standards of nursing education and service;

(b) to encourage its members to participate in affairs promoting the public welfare;

(c) to promote the best interests of the nurses

[illegible] Because the plans for the setting up of future schools of nursing are formulated the Association of Registered Nurses of Newfoundland should be consulted.

III. That in any future planning for the training of nurses Association of Registered Nurses of Newfoundland give leadership in this area, and draft specific plans to organize to improve and possibly expand the functions of this group.

IV. That we believe a University School of Nursing both on a post-graduate and an under-graduate level is essential to meet the future needs of this province.

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(a) to dignify the profession by maintaining and improving the ethical and professional standards of nursing education and service;

(b) to encourage its members to participate in efforts to protect the public welfare;

of the province and to maintain unity among them;

(d) to encourage an attitude of mutual understanding with the nurses of other countries, and

(e) such other lawful acts and things as are incidental or conducive to the attainment of the foregoing objectives.

MEMBERSHIP

Active membership as at December 1960 was 990.

FUNCTIONS

As stated in the Newfoundland Registered Nurses Act. A copy of which is included.

11. THE ASSOCIATION'S BELIEFS or CONVICTIONS WITH RESPECT to the PROVISION of HEALTH SERVICES for the PEOPLE of NEWFOUNDLAND.

Nursing care other than by duly qualified registered nurses should be carried out under the strict supervision of registered nurses. (We believe that certain schools may be set up in the future for the training of Nursing Assistants with a possible two year course which can not lead to the registered nurse status. It is desired that such Nursing Assistants should only carry out Nursing care under the supervision of duly qualified registered nurses).

111. NURSING SERVICE

(1) The Association of Registered Nurses of Newfoundland supports the statements contained in "Nurses-Their Education and Their Role in Health Programs", as prepared by the Canadian Nurses Association.
A copy of which is included.

of the province and be maintain unity among them;

(d) to encourage an attitude of mutual understanding with the nations of other countries, and

(e) such other laudable aims and things as are considered or conducive to the attainment of

[illegible]

Notice membership as at December 1971 was [illegible].

As stated in the Newsletter Registeers [illegible] Act. A copy of which is included.

THE [illegible] ACTS OF CONVENTIONAL WITH REGARD to the PROPERTY [illegible] AND [illegible] FOR THE [illegible]

Meeting are often then by only qualified registered nurses should be carried out under the strict supervision of registered nurses. (We believe that certain notions may be got up in the future for the training of Traditional Medicine with a possible two year course which can not lead to the registered nurses course. It is therefore that such Traditional Assistant's should only carry out the limiting case under the supervision of duly qualified registered nurses).

(1) The Association of Registered Nurses of Newfoundland supports the resolution contained in "Human Rights Declaration and Their Relationship Programme", as prepared by the Canadian [illegible]

A copy of which is included.

(2) Distribution of Nursing Personnel

Of the nine hundred and ninety actively registered nurses approximately six hundred and sixty-one are located in St. John's. The majority of nurses work in general hospitals, including cottage hospitals and sanatori, the remainder in Public Health, psychiatric nursing and private duty nursing.

A more detailed Brief will be presented at the final hearing in Ottawa.

Respectfully submitted
Association of Registered
Nurses of Newfoundland.

Pauline Laracy, R.N.
Executive Secretary

Jean E.C. Lewis, R.N.
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THE CHAIRMAN: In connection with your Association, you said you were incorporated by an Act of Parliament. I take it you mean the Newfoundland legislature?

MISS LEWIS: Yes.

THE CHAIRMAN: You are recommending affiliation with the cottage hospitals insofar as a training programme is concerned. Are the housing facilities available for such a programme?

MISS LEWIS: At the present time this is rather doubtful, but we hope that some arrangement could be made once plans were made for this particular programme.

THE CHAIRMAN: How many nurses do you visualize would go to any one cottage hospital, I mean at a time?

MISS LEWIS: About six.

THE CHAIRMAN: And for how long?

MISS LEWIS: We feel a month.

THE CHAIRMAN: Have you got the number that would provide that rotation? I mean, in the general hospitals where they have nursing schools?

MISS SOMMERS: We have the numbers sir, yes. We have more applicants for nursing than we can accommodate in the hospitals at the present time.

THE CHAIRMAN: That is, more girls are prepared to go into nursing than the nursing schools are able to accommodate?

MISS SOMMERS: At the present time.

COMMISSIONER GIRARD: Mr. Chairman, to pursue this question of student nurses going into cottage

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MISS SOMMERS: At the present time.

COMMISSIONER GIRARD: Mr. Chairman, to pursue this question of student nurses going into cottage

hospitals. The question comes up, would there be sufficient supervision to make this experience a worthwhile and educational experience?

MISS SOMMERS: Mr. Chairman, at the present time I would say no. This is one of the major factors in this programme, that specific plans would have to be made for the supervision of students away from the home school, so to speak, which we see as being a joint responsibility of the school and the Department of Health.

THE CHAIRMAN: By supervision, do you also include training, or just supervision, or supervised training I think is better?

MISS SOMMERS: Mr. Chairman, I don't quite understand what you mean by training?

THE CHAIRMAN: I will leave it to Miss Girard to tell us.

COMMISSIONER GIRARD: I think these nurses can be congratulated for not using the word training. I think there is a certain trend in the profession for getting away from the word training, but the older nurses like me still use it once in a while. I would like to bring out this point. I don't believe that there has been one brief presented here in Newfoundland since we have been listening to briefs which has not mentioned the shortage of nurses, so it is a very vital point in the health of the people in Newfoundland. I am gratified to see that at least in this brief some attempts are made to bring out certain aspects that could remedy the situation, and one of them is a statistical survey of all inactive nurses in Newfoundland has been carried out under the direction of the Association.

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MISS ROWNTREE: Mr. Chairman, at the present time I would say no. This is one of the major lessons in this programme, that specific plans would have to be made for the supervision of students away from the home school, so to speak, which we see as being a joint responsibility of the school and the Department of Health.

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Now, to go a little bit further, you have carried out the survey, have you been successful in bringing back to active nursing married nurses, and to what extent, because we do depend very largely now on married nurses?

MISS LEWIS: Miss Girard, we have only just recently completed this statistical survey. In fact, it was only last week that it was presented to the council of the association in its complete form.

COMMISSIONER GIRARD: Does it look encouraging?

MISS LEWIS: However, in going through this folder, we have found that there are quite a number of nurses listed as inactive that are now back practising nursing, and there are quite a number, both in St. John's and throughout the province.

COMMISSIONER GIRARD: It would be very interesting for the Commission to get a copy of this survey, if it were possible.

MISS LEWIS: I think this can be arranged.

COMMISSIONER GIRARD: The other consideration is the possibility of legislation for nursing assistants. Of course, we will recognize that the shortage of nurses could not be remedied immediately, and therefore that nursing assistants are necessary, and that we must see what we can do. Now, how far have you gone in this possibility, and what are your plans? I see that you say on the following page that specific plans be prepared to improve and possibly expand the functions of this group. I would be interested in knowing how you want to improve and expand, to what extent, the functions of the auxiliary nurse?

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and what are your plans? I see that you say on the following page that specific plans be prepared to improve and possibly expand the functions of this group. I would be interested in knowing how you want to improve and expand, to what extent, the functions of the auxiliary nurses?

MISS SOMMERS: Mr. Chairman, I don't think there has been any specific planning in this regard at the moment. Perhaps you are aware that in Newfoundland there is no particular course for nursing assistants that goes right across the province. We have several types of programmes for nursing assistants.

COMMISSIONER GIRARD: Under what auspices?

MISS SOMMERS: Under various auspices. The Department of Health has, I suppose you can say three plans under three different hospitals for the training of nursing assistants. The cottage hospital has a very limited training plan. I am not aware exactly of the extent of training in the hospitals that are not under government auspices. There are nursing assistants, I would say, in all of our hospitals in Newfoundland at various levels of preparation.

COMMISSIONER GIRARD: Has the Association of Nurses of Newfoundland considered being interested in a programme for nursing assistants, spelling out the curriculum or the functions, improving on the curriculum that exists in various places, or the one the Canadian Nurses Association worked out some years ago?

MISS LEWIS: Yes, we are working on one right now, as well as legislation.

COMMISSIONER GIRARD: This could also be very helpful to the Commission, if when this plan is written, a copy be sent to us. Thank you very much, Miss Lewis and Miss Sommers.

THE CHAIRMAN: I wonder, Dr. McGrath, if you have any comment to make on this suggestion of the rotation to the cottage hospitals of nurses from the nursi

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COMMISSIONER GRAHAM: This could also be very helpful to the Commission. If when this plan is written, a copy be sent to us. Thank you very much, Miss Lewis and Miss Somers.

THE CHAIRMAN: I wonder, Dr. McKenna, if you have any comment to make on this suggestion of the [illegible]

schools?

DR. McGRATH: We have had it in mind, but one of the difficulties has been pointed out, and that would be that the cottage hospital just would not have the accommodation to put six nurses in, but we feel it would be a good thing. It may be possible to do it in some of the cottage hospitals even now. We have not got actually down to the details of planning, but it is certainly something that is in our minds to do.

THE CHAIRMAN: Miss Sommers, if that could be done, how many additional nurses could your present schools of nursing take in, if this programme could be developed as you have suggested?

SISTER CALASANTIUS: At the present time we have our capacity admission. We would not be able to take any more.

THE CHAIRMAN: Even if you sent six out?

SISTER CALASANTIUS: Well, we could only take six, extra students.

THE CHAIRMAN: In how many schools?

SISTER CALASANTIUS: This is just our own school I am speaking for.

THE CHAIRMAN: But how many schools of nursing could do similar?

MISS SOMMERS: I think what Sister is referring to there is that the bed capacity in the residence set up, not the facilities of the hospital, and with the general hospital, as you are probably aware, is a bigger residence, and we could possibly take more students in. I think there is a limit to the number of students you co

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take in with relation to your hospital experience too.

THE CHAIRMAN: But if on consideration you were able to come up with some suggested figure, would you mind providing us with that figure with this supplementary information?

MISS LEWIS: Yes.

COMMISSIONER STRACHAN: I was wondering whether there was any consideration given to the training of male nurses, or male assistant nurses in this province?

DR. McGRATH: I think the answer to that is no. We have certainly thought of it, and looked at it you know, but it does not seem to us at the present time to be a practical thing. We have not completely abandoned it yet, because one of the advantages, of course, of male nurses, as well as other male personnel, is that you are likely to be able to keep them longer when they have completed training. We have very few, I think, in each of these institutions. I suppose they are practical male nurses, rather than, but there is no specific course, and I don't know of any male taking a nursing course in Newfoundland at the present time.

COMMISSIONER GIRARD: Why are you hesitant to bring in male nurses? It seems to be in some instances I think we are going to have to rely more and more in the future on male nurses. What are your specific reasons?

DR. McGRATH: I don't think they are specific. Firstly, of course, is the question of training space. At the present time, as has been said, all the training space has been utilized, but it is probably something that we could take a closer look at, yes.

VICE CHAIRMAN: But if on consideration you

[illegible]

MRS. LEWIS: Yes.

COMMISSIONER STRACHAN: I was wondering whether there was any consideration given to the training of male nurses, or male assistant nurses in this province.

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COMMISSIONER GIRARD: They could live outside the hospital?

DR. McGRATH: Yes, also the fact that I don't think we would get much recruitment.

COMMISSIONER GIRARD: Have you tried? I am pursuing this question because I am personally vitally interested in it now?

DR. McGRATH: It has not been tried, no.

COMMISSIONER GIRARD: And in an article that was written on it, I got some replies from New Brunswick, young men who wanted to come into training. I would be personally happy now to see a lot of young men come into training in nursing, because I feel there is a great place for them.

DR. McGRATH: I am willing to concede that it is possibly something we have not devoted enough attention to.

COMMISSIONER GIRARD: I think so. In some provinces they have the problem that they cannot have them in residence, all I know of have been living outside of residence, sometimes the hospital providing for them outside.

DR. McGRATH: I think it is probably one of the many things in Newfoundland that we have looked at that we see as possibilities, but we have been running so hard to stand still along some lines that we have not been able to develop some ideas that are probably sound in themselves.

COMMISSIONER STRACHAN: Does your Department of Education take advantage of the grant from the federal

they could live on.

[illegible]

[illegible]

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DR. MORGANTH: It has not been tried, no.

COMMISSIONER GIBSON: And in an e-mail that was written on it, I got some copies from new Commission. Young men who wanted to come into training. I would be personally happy now to see a lot of older men come into training in nursing, because I feel there is a great place [illegible].

DR. MORGANTH: I am willing to concede that it is possibly something we have not decided common education on.

COMMISSIONER GIBSON: I think so. In some provinces they have the problem that they cannot have men in residence, all I know of have [illegible] residency, sometimes the bunkies [illegible]

DR. MORGANTH: I [illegible] of the many things in newfoundland that we have looked at that we see as possibilities, but we have been running so hard to stand still along some lines that we have not been able to develop more areas that are probably sound in themselves.

[illegible]

[illegible] education take advantage of the grant from the federal

government towards training of nurses' aides?

DR. McGRATH: I don't think at the present time, no, but while I am not making a clear pronouncement of that at the present moment, we are considering the need to train a large group of nurses' aides, because of the new hospitals opening in about a year's time and the problem there is the same as with the nurse, to provide living space. That is under active consideration at the present moment, and if we do go ahead we will be in touch with the Department of Education.

COMMISSIONER VAN WART: I might ask the nurses, aides are used in your hospitals, are they not, at the present time?

MISS LEWIS: Yes.

COMMISSIONER VAN WART: Are they all trained on the mainland?

MISS SOMMERS: Mr. Chairman, are you differentiating between ward aides and nursing assistants?

COMMISSIONER VAN WART: I am taking the higher category, nursing assistants is it not?

MISS SOMMERS: Well, in Newfoundland we don't, where there is a training programme we call it a nursing assistant.

COMMISSIONER VAN WART: In that programme, do they receive a certificate as a qualified nursing assistant?

MISS SOMMERS: From the hospital.

COMMISSIONER VAN WART: Which is on a par with, say, the school in Moncton, New Brunswick?

MISS LEWIS: In certain circumstances it is

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MRS. SOMMERS: From the hospital.

COMMISSIONER VAN WART: Which is or a [illegible] with, say, the school in Moncton, New Brunswick?

MRS. LEWIS: In certain circumstances it

accepted, I believe the other provinces look into it individually, and sometimes require them to write another examination, and sometimes accept them.

COMMISSIONER VAN WART: The standard varies in various hospitals where you train these, is that correct?

MISS SOMMERS: Well, I can only talk with authority on the one in my own particular hospital, which is a general training programme, and that does compare favourably, I think, with the D.V.A. programme for nursing assistants in the rest of Canada.

COMMISSIONER VAN WART: How long is that training programme?

MISS SOMMERS: It is a ten-month programme.

DR. MILLER: I don't believe it has been clearly stated that there are four hospitals in Newfoundland at the present time, at least four, that are operating, or let me say educational experiences for this type of person. The general hospital in St. John's, the two tuberculosis sanitoria, and a hospital for mental and nervous disorders. It trains men as well as women. I don't believe that the courses have been formally recognized anywhere, but I do know that institutions in the Maritimes have been constantly robbing us of people after we have trained them.

THE CHAIRMAN: Thank you, Dr. Miller.

COMMISSIONER GIRARD: One more question. We believe thatthe University School of Nursing, both on a post-graduate and under-graduate level, is essential to meet the future nursing needs of this province. Do you foresee that the University School would add in numbers

COMMISSIONER VAN WART: The standard varies in various hospitals where you train these, is that correct?

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We believe that the University School of Nursing, both on a post-graduate and under-graduate level, is essential to

very extensively, or in quality, or in training, in preparing leaders in nursing?

MISS SOMMERS: I would believe in the latter more than in numbers.

COMMISSIONER GIRARD: It would not help very much to relieve the shortage, but it would give you qualified people to open new schools, and such, is that what you are striving for?

MISS SOMMERS: It would increase the numbers in that area, because again our transportation -- people don't tend to go away in great numbers and take courses in universities and come back.

COMMISSIONER GIRARD: Are you thinking of a basic degree course in the university or only a post-graduate course?

MISS SOMMERS: Both.

THE CHAIRMAN: Do you visualize any such course in the absence of a medical school?

DR. McGRATH: Yes, it is under negotiation at the moment with the university. It has not yet been worked out, but we have been in touch with the university, and the matter is under active consideration at the present moment.

COMMISSIONER BALTZAN: In what way is that going to operate, I am referring specifically to the under-graduate nurses. In other words, is that absolutely essential for the under-graduate nurses? Is not an organized departmentalized teaching general hospital sufficient to fill the bill, or must it be associated with the university in order to acquire these skills and training?

MISS SOMMERS: I would believe in the labor-

COMMISSIONER GIRARD: It would not help very much to relieve the shortage, but it would give you qualified people to open new schools, and such, in that what you are striving for?

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COMMISSIONER BAITSAN: In what way is that going to operate, I am referring specifically to the under-graduate nurses. In other words, is that absolutely essential for the under-graduate nurses? Is not an or-

DR. McGRATH: I think it is a matter of higher education, and possibly more technical education in sciences and things like that, but of course the course itself would have to be worked out in conjunction with the nursing training schools and the hospitals.

THE CHAIRMAN: I take it that what you are looking for is eventually your own instructors and supervising personnel?

DR. McGRATH: Yes, partly. There is another aspect of it. That is that there are a number of girls who have the educational qualifications to enter nursing, but haven't reached the age which we consider the minimum age at which they should enter, and we feel that some of them are lost to nursing because of having to wait a year.

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THE CHAIRMAN: I take it that what you are looking for is eventually your own instructors and supervising personnel?

DR. McNEATH: Yes, partly. There is another aspect of it. That is that there are a number of girls who have the educational qualifications to enter nursing, but haven't reached the age which we consider the minimum age at which they should enter, and we feel that some of them are lost to nursing because of having to wait a year.

If they could enter the nursing course at the university at that age, we feel a number of the potentially and possibly desirable ones would be saved to the profession, if they did not have to wait that year. What that will mean in volume, I don't know, but it is worth considering.

COMMISSIONER FIRESTONE: Mr. Chairman, may I follow that up with a question on the recommendation IV on page 2, the establishment of a university school of nursing. Would it be possible to receive from the Association of Registered Nurses of Newfoundland a subsequent submission in writing to this Royal Commission after consultation with the Department of Health and Dalhousie University, giving us an indication of the kind of school that you have in mind, the capital budget of such a school and the operating budget of such a school, the teaching staff required and the number of student nurses you expect to train annually over a five-year period after the establishment of such a university school of nursing?

COMMISSIONER VAN WART: May I supplement the University of New Brunswick with the Dalhousie University where they have at present a school of nursing.

DR. MILLER: For your information, Mr. Chairman, the University authorities have already been in contact with both the Fredericton and Halifax schools on this subject.

COMMISSIONER FIRESTONE: Assuming you have this consultation, we still would be interested in the views of the Newfoundland Nursing Association, if we may have them.

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25 in contact with both the Fredericton and Halifax schools
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27 COMMISSIONER FIRESTONE: Assuming you have
28 this consultation, we still would be interested in the

MISS LEWIS: Yes, we will look into this and get the necessary information.

THE CHAIRMAN: Thank you very much, Miss Lewis and your associates.

Ladies and gentlement, that completes the hearing of submissions from all those who signified an intention to make a submission and, naturally, that brings to a close the public hearings here in this province.

Before we close I want on behalf of the Commission and our staff to thank those who have participated in these hearings. The submissions which we have received have been very much worthwhile. They have contained many constructive ideas and suggestions which are going to require study, and they indicate that there is a great volume of leadership in the health services field forthcoming in this province, and I want particularly to thank Dr. McGrath and his department and Dr. Miller for being in constant attendance at this hearing, and helpful from time to time with answers and information. Dr. McGrath's help does not finish here: He has arranged that the Commission will have an opportunity to see working one of the cottage hospitals and we are going to do that tomorrow, because this cottage hospital programme is unique in this province, and it is the only opportunity we will have to see how it works out in practise. We are also to have the hospitality of the province later this afternoon for which we are also grateful, and so we want to thank everyone who has contributed to making these hearings the success that we believe they have been. Thank you very much.

----------Adjournment.

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----------Adjournment.

ROYAL COMMISSION ON HEALTH SERVICES

HEARINGS

HELD AT

CHARLOTTETOWN

P. E. I.

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ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the hearing
held at Charlottetown, Tuesday,
November 7th, 1961.

COMMISSION MEMBERS:

Chief Justice EMMETT H. HALL -- Chairman

Miss ALICE GIRARD, R.N.

Dr. DAVID M. BALTZAN

Prof. O.J. FIRESTONE

Mr. M. WALLACE McCUTCHEON, Q.C.

Dr. C.L. STRACHAN

Dr. ARTHUR F. VAN WART

COMMISSION COUNSEL:

Mr. R.N. HALL, Q.C.

MEDICAL CONSULTANT:

Dr. PIERRE JOBIN

DIRECTOR OF RESEARCH:

Prof. BERNARD BLISHEN

SECRETARY:

Maj. N. LAFRANCE

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held at Charlottetown, Tuesday,
November 7th, 1951.

COMMISSION MEMBERS:

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Miss ALICE GLARK, R.N.

Dr. DAVID M. BALTZAN

Prof. O.J. FINNSTONE

Mr. M. WALLACE McCUTCHEON, Q.C.

Dr. C.L. STRACHAN

Dr. ARTHUR F. VAN WART

DIRECTOR OF RESEARCH:

Prof. BERNARD BLISHEN

SECRETARY:

Charlottetown, P.E.I.,
Tuesday,
7 November, 1961.

--- On commencing at 10:00 a.m.

THE CHAIRMAN: Mr. Minister, ladies and gentlemen, as advertised, the Commission is now opening its sitting in the Province of Prince Edward Island to receive submissions from all who wish to make submissions or to submit briefs. We are here to pursue the inquiry that has been entrusted to the Commission by the Government of Canada under the Order-in-Council which constituted the Commission. We have a very broad field to investigate, and to do so we require the cooperation and help of all organizations who are interested in health services throughout Canada. That is why we are here, to receive these submissions, to discuss them with those who are making recommendations, and to gather all the relevant information so that in due course we may be able to make a report which we trust will be of some ultimate value in this very important subject of health services.

The proceedings are now underway in the Province of Prince Edward Island.

THE HON. McNEILL: Chief Justice Hall, ladies and gentlemen of the Royal Commission, on behalf of the Province of Prince Edward Island it is my great pleasure to welcome you to Prince Edward Island. We know that your duties are very important; they are important to citizens of Prince Edward Island, and indeed to all the

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The proceedings are now underway in the Morland

THE HON. MINISTER: Chief Justice Hall, ladies

Our duties are very important; they are important to

citizens of Canada. We hope that you will have time while you are here to partake of the hospitality of Prince Edward Island. We hope your duties will not be so arduous that you will not have time to enjoy the hospitality for which I believe the Province of Prince Edward Island is noted. We are sorry that you didn't arrange your visit here for the summer, because we know in the summertime our province is at least as beautiful as any other province of Canada, and I am sure if you had made arrangements to come in the summertime that you would have stayed for at least a week because you would have had much more to do here on the island.

As you know, Charlottetown is, we believe, the cradle of Confederation. It is here pretty near one hundred years ago that the idea for a united Canada under Confederation was fir instigated. Sometimes we feel we in Prince Edward Island did not receive all the benefits we had hoped. Nevertheless, we are very proud to be part of Canada and very proud indeed to be the cradle of Confederation.

I know, Mr. Justice Hall, you are more familiar in such surroundings as these, in the law courts of our province, and you are probably much more at home here than the members of the Commission and the people who are presenting briefs. I assure you, sir, we will give you every cooperation.

My department, the Department of Health, will give you every cooperation, and I am sure the Medical Society, the Home and School Association, the Prince Edward Island Dental Assocation, the Association of Nurses

while you are here on behalf of the hospitality of Prince Edward Island. We hope your duties will not be so arduous that you will not have time to enjoy the hospitality for which I believe the Province of Prince Edward Island is noted. We are sorry that you didn't arrange your visit here for the summer, because we know in the summertime our province is at least as beautiful as any other province of Canada, and I am sure if you had made arrangements to come in the summertime that you would have stayed for at least a week because you would have had much more to do here on the island.

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I know, Mr. Prince Hall, you are more familiar in such surroundings as these, in the law courts of our province, and you are probably much more at home here than the members of the Commission and the people who are presenting briefs. I assure you, sir, we will give you every cooperation.

My department, the Department of Health, will give you every cooperation, and I am sure the Medical Prince Edward Island Dental Association, the Association of Nurses

of Prince Edward Island, the Canadian Mental Health Association and the Prince Edward Island Association for Retarded Children all have very interesting briefs, and I hope they will add to your already large amount of knowledge which you have no doubt received since the time of your Commission.

As this is a small province, the services rendered by my department are perhpas more closely integrated with the operations of general hospitals and the work of private practitioners than in the case of a larger province. This is evident when one considers the high proportion of private practitioners who serve on various boards and committees and form an integral part of hospital insurance and Department of Health programs. For this reason I have decided to cooperate with the Prince Edward Island branch of the Canadian Medical Association in the preparation of a single brief which will provide a comprehensive picture of the health services provided in our province. My department has supplied material for this brief in so far as the public health services are concerned, and the Hospital Services Commission has provided the information on hospital insurance programs. I believe that suggestions for the improvement of such services are reasonably valid, but I wish to point out that the portions of the brief dealing specifically with medical care have been prepared by the Medical Society for which the society is totally responsible. I feel that the method which we have adopted will result in elimination of duplication of material which would have

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been presented under separate briefs.

Again, on behalf of the Province of Prince Edward Island and on behalf of the citizens of Prince Edward Island and on behalf of the people who present briefs, I wish to welcome you to Prince Edward Island, and I am sure your stay will be enjoyable.

THE CHAIRMAN: Thank you very much, Mr. McNeill. Had we been able to arrange matters for a different season of the year, I am sure we would have been very happy to do so. Even as it is, I think to most of us this weather is still very balmy weather, and from the report my associate, Dr. Baltzan, had from Saskatchewan this morning, we hear it is snowing and very cold. So, we are still most happy to be in Prince Edward Island.

Your presence here this morning speaking on behalf of the government of the province, speaking on behalf of the province itself, is a most welcome thing. As you know, and as is generally known, this matter of health services is in a great measure, perhaps not exclusively, but in a great measure one under provincial jurisdiction, and in any inquiry the order-in-council specifically draws to the attention of the Commission the dual nature of the responsibility, and that the matter of health is in a great measure the responsibility of the province, and so to carry on an inquiry that will be worthwhile we necessarily need the support and cooperation of the provinces, and we are deeply grateful to you, Mr. Minister, for being here and offering that cooperation and for your

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part in the preparation of the brief we are going to hear. Thank you very much.

THE HON. McNEILL: I would now like to introduce the president of the Prince Edward Island branch of the Canadian Medical Association, the Hon. Dr. George Dewar.

DR. DEWAR: Hon. Mr. Chairman, Justice Hall, honourable members of the Royal Commission on health care, it is a pleasure for me as president of the Prince Edward Island division of the Canadian Medical Association to welcome you all to the province of Prince Edward Island. We realize that your job is not an easy one, that you have a lot of travelling to do, and that you have a very wide field to investigate. It is a pleasure, as a member of the Association which endeavours to provide medical services to the people in Prince Edward Island, to welcome you here.

I might say that in our submission to you we feel that we have tried to prepare something carefully and something that will be of use to you in arriving at your conclusions. It is a pleasure to the Medical Association that we have had the cooperation of our Department of Health to the full in the preparation of this brief. I think it is a good sign that there should be cooperation between those who endeavour to provide medical services on the one hand, and the government on the other which endeavours to assist in seeing that the services are fairly and equally divided among all the people of the province. We trust that your deliberations here will be instructive

THE HON. MEMBER: I would now like to introduce the president of the Prince Edward Island branch of the Canadian Medical Association, the Hon.

[illegible]

Honourable members of the Royal Commission on Health Care, it is a pleasure for me as president of the Prince Edward Island division of the Canadian Medical Association to welcome you all to the province of Prince Edward Island. We realize that your job is not an easy one, that you have a lot of heavy lifting to do, and that you have a very wide field to investigate. It is a pleasure, as a member of the Association which endeavours to provide medical services to the people in Prince Edward Island, to welcome you here.

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and that you will obtain something practical from this hearing.

As the Minister of Health told you, we are proud that our province is known as the Cradle of Confederation, and we feel also it is an ideal nursery for all phases of national development and we hope that it will become known as that also.

I would like to introduce to you our Chairman of the Executive Committee of our Society which we set up to prepare our submission. The members of that committee were, Dr. Clarence Coady as Chairman, Dr. Roy Grant, of Summerside, and Dr. Gordon Lea of Charlottetown. I would like to say a word of appreciation to these gentlemen for all that they did in preparing this submission to you. I would now ask Dr. Clarence Coady to submit our brief to you and to introduce the members of his committee.

DR. COADY: Mr. Chairman and members of the Royal Commission, as you might well realize, the preparation of the document which we have placed in your hands has not been by any means the result of the efforts of any one man or even of the efforts of any three men, and I would like to introduce to you at this time the members of our society who have contributed to the production of the brief which we are presenting to you this morning.

---All members of society shown in appearances were introduced to the Commission at this point.

These are the men, Mr. Chairman and Commissioners, who have contributed to the preparation

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DR. GEARY: Mr. Chairman and members of the Royal Commission, as you might well realize, the preparation of the document which we have placed in your hands has not been by any means the result of the efforts of any one man or even of the efforts of any three men, and I would like to introduce to you at this time the members of our society who have contributed to the production of the brief which we are presenting to you this morning.

---All members of society shown in appearances were introduced to the Commission at this point.

These are the men, Mr. Chairman and Commissioners, who have contributed to the preparation

of our brief. These are the people to whom I hope you will feel free to direct your questions and your discussions which will follow the summary which I am about to read to you. I will likewise feel free, myself, with your permission, to redirect all questions that you may direct to me to the man in this group whom I feel is best qualified to answer any particular question.

I have two other items which I would like to bring to your attention before I read the summary. The first is that some of the members on our panel have had some second thoughts about the summary which we included in the front part of our presentation. Some of us have thought that in our rush to meet the deadline that this did not lend itself quite as well to the promotion of discussion as it might have if it had had a little different form. So, we have, with your permission, rewritten our summary changing the form without changing the content, and I would like to circularize among you our rewritten summary for your guidance.

The second thing which I wish to bring your attention before I proceed is a small alteration which I am require to make in the appendix portions of our brief, and if you will turn to the back portions of our brief which include our appendices, and turn to appendix D, and having arrived at appendix D, turn to page 3, and on page 3, paragraph 7 -- the top paragraph -- we have had to change this paragraph as follows:

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Strike out "similarly, though"; and it should read only down to the comma after the word "present"; strike out everything after the comma.

This paragraph should read:

"We have no facilities, for inpatient treatment of severly disturbed children at present."

With that, and with your permission, I would like to read to you the summary of our brief.

President: Honourable George Dewar, M.D., O'Leary, P.E.I.

Secretary: Fred Whitehead, M.D., East Riverside, N.B.

Executive Committee on Health Services

Chairman: Clarence Coady, M.D. Charlottetown, P.E.I.

Members: Gordon Lea, M.D., Charlottetown, P.E.I.

Roy Grant, M.D., Summerside, P.E.I.

Contributors: Arthur Kelly, M.D., Toronto, Ont.

J.A. MacMillan, M.D., Charlottetown, PEI

Honourable Hubert MacNeill, M.D., Minister of Health, Summerside, P.E.I.

Burton Howatt, M.D., Charlottetown, P.E.I.

John Craig, M.D., Charlottetown, P.E.I.

Eric Found, M.D., Charlottetown, P.E.I.

L.E. Prowse, M.D., Charlottetown, P.E.I.

Malcolm Beck, M.D., Charlottetown, P.E.I.

J.H. Maloney, M.D., Charlottetown, P.E.I.

Strike out "similarly, though";

and it should read only down to the comma after the word "present"; strike out everything after the comma.

This paragraph should read:

"We have no facilities, for immediate treatment of severely disturbed children at present."

With that, and with your permission, I would like to read to you the summary of our brief.

O'Leary, P.E.I.

Secretary: Fred Whitehead, M.D., West Riverside, N.B.

Executive Committee on Health Services

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Charlottetown, P.E.I.

Roy Grant, M.D., Summerside, P.E.I.

Contributors: Arthur Kelly, M.D., Toronto, Ont.

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Honorable George Dewar, M.D.
O'Leary, P.E.I.

VICE-PRESIDENT

Edward Kassner, M.D.
Souris, P.E.I.

SECRETARY

Fred Whitehead, M.D.
East Riverside, N.B.

EXECUTIVE COMMITTEE ON HEALTH SERVICES

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Charlottetown, P.E.I.

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Fred Whitehead, M.D.

Clarence Coady, M.D.

Roy Grant, M.D.

Honorable Albert Mayhew, M.D.
Minister of Health

Earlon Howatt, M.D.

John Healy, M.D.

J. J. Maloney, M.D.
Charlottetown, P.E.I.

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(Based on Terms of Reference)

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SUBMISSION OF THE MEDICAL SOCIETY OF
PRINCE EDWARD ISLAND CANADIAN MEDICAL ASSOCIATION
PRINCE EDWARD ISLAND DIVISION

SUMMARY

Mr. Chairman and Members of the Royal Commission on Health Services.

1. We the Prince Edward Island Division of the Canadian Medical Association welcome this opportunity to express to you our thoughts on the problem of health in Canada, with special reference to Prince Edward Island. We have placed in your hands a submission which embodies briefly the existing situation in this province as well as suggestions for improvement of the standard of health of the people of this area.

PRIVATE PRACTICE

2. We believe that health services provided by private practitioners in this province are of the highest quality, and we are convinced that nothing must be permitted to interfere with the pattern of practice of this group of physicians. This, in essence, requires:

(a) That the physician-patient relationship must remain undisturbed.

(b) That the physician's first responsibility must continue to be to his patient and not to any third party.

(c) That the principle of fee for service must be retained.

3. We believe that many private practitioners, especially in rural areas, are carrying an excessive work load, and we recommend that studies be initiated

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into ways and means to facilitate the provision of health services in these areas.

4. Physicians over the years have demonstrated a keen interest in the evolution of prepaid medical care plans. We have reached some definite conclusions regarding the principles which must form the basis of any such plan. These are embodied in the "Statement of the Canadian Medical Association on Prepaid Medical Care Insurance".

GOVERNMENT AGENCIES

5. Government Agencies have provided or financed health services in special fields for many years.

(a) We believe this policy should be continued, with modifications as necessary, when any province-wide prepaid medical care insurance plan is adopted.

(b) In the field of Mental Health we recommend that every effort be made to promote conditions whereby an adequate and permanent type of psychiatric service may be made available to our citizens.

(c) We suggest too that our patients in mental hospitals should not be excluded from the benefits of the Hospital Insurance Plan.

(d) We further recommend that facilities be provided for the adequate treatment of alcoholism.

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6. While it would appear that there is a

shortage of acute care beds in the Summerside area, and of chronic care beds in the Charlottetown area, we believe that the needs in this field as well as in the field of custodial care beds, are poorly defined and would recommend that further study be given to this problem.

7. We endorse the method of administration of the Hospital and Diagnostic Services Insurance Plan in this province and urge that this method be retained.

MEDICAL PERSONNEL REQUIREMENTS

8. To insure an adequate supply of well qualified physicians for our future needs we urge that:

(a) Under any circumstances and at all times, conditions must be maintained such that postgraduate study and research are fostered.

(b) At the same time the importance of a good public image of the physician cannot be overestimated if recruits are to be attracted to this profession.

PREPAID MEDICAL CARE INSURANCE PLAN

9. In proposing a Prepaid Medical Insurance Plan for the people of Prince Edward Island we submit that, to be successful, such a plan:

(a) Must be acceptable to the profession and receive their full co-operation.

(b) Must not impede scientific study or research.

(c) Must not interfere with the democratic rights of any citizen.

(d) Should be administered by voluntary

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(d) Should be administered by voluntary

carriers who can conform to certain specified qualifications.

(e) Must provide all necessary in and out of hospital medical service.

(f) May make available paramedical benefits and extended benefit insurance but that these if provided should be administered and funded separately from the necessary purely medical benefits.

10. It is proposed that:

(a) Self supporting citizens should pay their own premiums.

(b) Certain other groups will require government assistance in full or in part to enable them to do so.

(c) The basis for payment to physicians should be the Schedule of Fees of the Prince Edward Island Division of the Canadian Medical Association which must remain subject to periodic revision.

11. The projected cost of this plan for all the people of the province at $20.00 per capita is $2,000,000.00, the cost to government is estimated at $400,000.00 while self paying subscribers contribute $1,600,000. We believe that such a plan has many advantages over any alternate proposal and we submit that, with financial assistance available to those groups requiring it, a large percentage of our population will procure medical care insurance if encouraged to do so.

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Mr. Chairman and Members of the Royal Commission on Health Services:

Para. 1 The Prince Edward Island Division of the Canadian Medical Association is the official organization representing the medical profession of this province. On behalf of this organization we hereby present, for your consideration, a submission concerning the present status of health services in this province, the deficiences which we believe to exist in these serives, along with some recommendations for correcting or improving these deficiencies, with a view to improving these health services.

Para. 2 The population of this province has remained relatively fixed for the past several years and in 1961 stands at 103,000 people. The last available census figures indicate 60% of the population are rural residents and 40% urban. The rural population is located uniformly throughout the province with only a few areas that could be considered sparsely populated. It is estimated that no resident of this province lives farther than fifteen miles from medical services.

MEDICAL PERSONNEL

Para. 3 The Medical Association here is composed at present of ninety members, giving a physician population ratio of 1:1,140. Seventy-seven general practitioners and specialists are directly concerned with the provision of health services to the people of the province through private practice while thirteen are salaried physicians employed full time in various administrative or clinical posts of the different divisions of Government.

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The breakdown of the members into general practice or specialty groups and their rural-urban distribution is shown in Appendix A.

Para. 4 The qualifications of any medical practitioner in this province, as in other parts of Canada, are carefully scrutinized to insure the highest standard of medical proficiency before any medical candidate may procure a license to practice in the province.

Para. 5 Some 84% of the present practising physicians are graduates of Canadian Medical Universities. They have been required by these Universities, to meet a high standard of pre-medical education, to have successfully completed the four year medical course, to have had at least one year of approved hospital internship, and finally to have successfully passed the examinations of the Medical Council of Canada.

Para. 6 Some of the remaining 16% of the practising physicians have become eligible for registration in this province by reciprocal arrangement with the Medical Council of Great Britain whose standards of quality are equivalent to the standards of the Medical Council of Canada.

Para. 7 The balance of the practitioners are graduates of foreign Medical Schools whose credentials have been carefully scrutinized, who have completed a minimum of one year internship at an approved Canadian hospital, who have been issued an enabling certificate on the recommendation of the medical staff of that hospital, approved by the Medical Council of the province, and who then have successfully passed the examinations of

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[illegible]

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Para. 5 Some 3% of the present practising physicians are graduates of Canadian Medical Universities. They have been required by these Universities, to meet a high standard of pre-medical education, to have successfully completed the four year medical course, to have had at least one year of approved hospital internship, and finally to have successfully passed the examinations of the Medical Council of Canada.

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the Medical Council of Canada.

Para. 8 Many of these physicians have pursued their studies further and have become specialists in one of the several specialties as enumerated in Appendix A.

Para. 9 Matters of professional conduct and quality of medical service provided by physicians are governed by the provisions of the Medical Act of Prince Edward Island as revised in 1952, and by the code of ethics of the Canadian Medical Association.

Para. 10 The body charged, under the Medical Act of Prince Edward Island, with the implementation of the provisions of the Act in respect to registration, licensing and discipline is the Medical Council of Prince Edward Island. This body consists of seven members, six of whom are elected by the Prince Edward Island Division of the Canadian Medical Association, and one appointed by and representing the Provincial Minister of Health. In matters concerning breaches of the provisions of the Act, the Medical Council has the authority, within specified limits, of dealing with or disciplining the offending member. In addition to, and apart from breaches of the provisions of the Medical Act, the Prince Edward Island Division, Canadian Medical Association may, under the provision of the by-laws of the Division, deal with matters concerning inter-professional relationship, professional conduct, relationship between patient and physician, and other such matters.

Para. 11 The Medical Council of Prince Edward Island has set standards for, and maintains, the register of Specialists of Prince Edward Island.

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Para. 11 The Medical Council of Prince Edward Island

Para. 12 The members of the Medical Staffs of the Prince Edward Island Hospital, the Charlottetown Hospital, the Prince County Hospital, the Provincial Sanatorium and Rehabilitation Center, and Riverdale Hospital are governed by their respective hospital by-laws. These hospitals have all been approved by the Canadian Council on Hospital Accreditation, and the application of their by-laws ensures a high standard of medical service and professional conduct. Sixty-six of the practising physicians in the province are on the medical staff of one or more of these institutions, and are thus subject to the provisions of by-laws that have the approval of the Canadian Council on Hospital Accreditation. The remaining physicians in private practice are on the staffs of one or other of the five smaller hospitals.

Para. 13 The Prince Edward Island Division of the Canadian Medical Association and the Prince Edward Island Chapter of the College of General Practice have both carried on, for many years, an active program of post-graduate training in which they have had the assistance of the Post-Graduate Department of Dalhousie University. The Prince Edward Island Chapter of the College of General Practice has twenty-five members who participate in the extension training program sponsored by the College.

Para. 14 There are thirty-three registered specialists in the Province and these include all the major specialties with the exception of Neurology, Neuro-Surgery and Cario-Vascular Surgery. Cases, both elective and

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emergency, requiring the services of a Neuro-Surgeon are transferred to the Victoria General Hospital in Halifax. The Provincial Department of Health has been providing consultation service in Neurology by having a Neurologist from Halifax make regular trips to Charlottetown where he sees referred cases. Cases requiring the services of a Cardio-Vascular surgeon are referred to Halifax, Montreal, or Toronto. The recent establishment of Cardio-Respiratory Unit at the Charlottetown Hospital will, it is expected, reduce the number of cases leaving the province for investigation in this field.

MEDICAL SERVICE PROVIDED IN PRIVATE PRACTICE

Para. 15 As the figures mentioned earlier have indicated that some 86% of our total members are in private practice, it is to be noted that the vast bulk of medical services are rendered by this group of practitioners, some of whom may participate, on a part-time basis, in health care projects undertaken by a Division of Government or other agency.

Para. 16 The pattern of medical practice in this province is one in which every citizen enjoys the right to consult the physician of his choice, while the physician enjoys the right to choose the type and location of his practice. Consultations by appropriate specialists are freely utilized, and to facilitate this and promote high quality care, group clinics composed of physicians working in voluntary association have become established in some areas.

Para. 17 Under this system of medical practice, we believe that health services of the highest possible order

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are made available to the people of this province. We are convinced that in competitive private practice, quality of medical care, including the full use of specialist consultation when indicated, the personal interest of the physician in the whole patient and his family, and consideration for his financial circumstances, are factors of paramount importance to the practitioner and ultimately do determine his success or failure in the community.

Para. 18 In the sixty years of the twentieth century under this system of medical practice great strides have been made in improving the standard of health of the community. Many diseases which formerly carried a high mortality and morbidity have been virtually vanquished; life expectancy has been increased from forty-seven years in 1900 to seventy years in 1960 and these years have been made more enjoyable with the application of medical science's increasing ability to relieve suffering and disability. -- It is interesting to note that 95% of our maternity cases are now handled in our general hospitals.

Para. 19 This improvement in the standard of health and progress in the art and science of medicine has been the result of several factors, chief of which are:

1. The philosophy of medicine.

The philosophy of medicine maintains that a living person is better than a dead one, that a well person is better than a sick one. Such a realistic and concrete concept clearly marks the road along which

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medicine must travel.

2. Freedom.

The medical man throughout history has made progress in an atmosphere of freedom. He has been free to choose the type and location of his practice, free to try new drugs and methods, free to discard old ones, free to seek knowledge, free to specialize and, not least, free from excessive and time consuming non-medical administrative demands. In short, he has been free to follow the philosophy of medicine and devote his professional skill to the treatment of the sick.

3. Utilization of Scientific Advancement.

Medical Science has sought eagerly and applied fully new knowledge evolved in the fields of chemistry, physics, biology, electronics, etc. and as a result thereof has made available to the general public the benefits of these scientific advancements.

Para. 20 Many other factors have over the years contributed in no small way to the increasing benefits derived from medical services as provided by private practitioners. Improved methods of communication and transportation have made it possible for the physician to distribute his services over a much wider area and with much less time and hardship. The utilization of the

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services of paramedical personnel such as nurses, orderlies, physiotherapists, pharmacists, laboratory technicians, dieticians and many others have left him with more time to devote to the art and science of medicine to the benefit of all.

RECOMMENDATIONS

Para. 21 . However as increasing demands for medical services in rural areas continue to be made in this province we recommend that studies be initiated to resolve the difficulties of the rural practitioner in providing medical services to their patients approaching those avilable to the urban population including:

1. Establishing a pattern of practice whereby the responsibility of bringing the patient to the physician rests upon the family or community.
2. Greater utilization of paramedical personnel and services.
3. Greater utilization of modern means of communication and transportation.
4. Overcoming the difficulties of adverse rural travelling conditions.
5. Mechanisms for attracting physicians to low income rural areas.

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4. Overcoming the difficulties in [illegible] physicians to low income rural [illegible]

THE ROLE AND PHILOSOPHY OF THE PRIVATE PRACTITIONER IN THE DEVELOPMENT OF PREPAID MEDICAL CARE INSURANCE

Para.22 We submit that medical care of a high quality has been available to the people of this province for many years. The philosophy of medicine, freedom, and the utilization of scientific advancement, have provided the climate so necessary for this growth. We believe the public appreciate all these facts. Their intense interest in the improvement of services, and more particularly in our efforts to provide newer methods of prepaying medical care has encouraged us to increase our efforts to meet this new challenge. Indeed it is essentially the combined efforts of the public and the profession that alone can safeguard the basic freedoms so necessary to a satisfactory evolution of medical service, without the introduction of an administrative third party capable of separating the patient from his physician and undermining the basic freedoms and rights of both.

Para. 23 We wish to emphasize that the aspect of health service which over the years has been so eminently successful in providing first class health care to the citizens of this country, must not be sacrificed nor jeopardized in our attempts to solve the economic and financial aspect of the overall health care problem. Acknowledging as we must that quality of medical service has and must continue to take priority over the financial aspect of this problem, the

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profession has not been unaware of the importance of this latter aspect, and indeed have been active in the promotion of prepaid medical care plans on a non-profit basis for many years. Indeed as we will subsequently show, Maritime Hospital Services Association in this area has been initiated and sponsored by the medical profession and at present is providing prepaid medical service to 20% of the population of this province over and above those insured by commercial carriers.

Para. 24 By tradition the physician like the artist was an individualist. Both his art and his knowledge were personal and he developed them in his own way. Private practice to him depended on his being able to attract patients by his person skill and reputation.

Para.25 Today scientific medicine, cold and mathematical as it may seem to some, is the common heritage of all doctors. Scientific medicine is in a state of continuous change. Although any given doctor may change, from time to time, the science he applies to his patient's cause, his art is still as personal and private as ever.

Para. 26 And so it was with the economics of medical practice. The labourer is worthy of his hire. But in recent years the mathematics of statistics, mass coverage of risks by insurance, and the need of patients for some form of periodic prepayment for services, as well as installment buying in other phases, brought to the doctor a new and unfamiliar problem in medical economics.

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Para. 27 In the face of these circumstances the medical profession of North America launched into the experiment of the prepayment of medical services for families, a field untouched by the old line insurance industry. The history of the sponsorship, financing, the trial and error, in this field will be told to you elsewhere. The history and the practices of the medically sponsored plans as well as their successes and their failures will also be in your hands.

Para. 28 The profession in Prince Edward Island and our Island people accepted this new approach as elsewhere. As a non-industrial province we were somewhat less conscious of the fringe benefit aspects of health services insurance; as a low income area we were perhaps less capable of taking full advantage of its widest implications; as a rural people we did not have the advantages of the group approach.

Para. 29 Since 1943, we have made use of M.H.S.A., first for hospital services insurance and later for medical and other benefits. We have gradually developed with our confreres from New Brunswick, medical service insurance on a service basis. During this time we have studied these problems long and arduously. As private practitioners we have disagreed on many of the problems involved but with our confreres across the land we have come to some very definite conclusions on which we have strong convictions based on experience and long study.

1. No prepayment service plan or mechanism can build for itself the capacity to succeed on its own. On us, the medical

[illegible] expansion of North America launched into the [illegible]

[illegible]

[illegible]

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Para. 47 Since 1945, we have made use of M.H.[illegible] funds for municipal services increases and later for [illegible], and other benefits. We have gradually developed with our conferences from New Brunswick, [illegible] services [illegible] on a service basis. During this time we have [illegible] these problems long and arduously. As private [illegible] we have disagreed on many of the problems involved but when we surveyed across the land we have [illegible] very definite conclusions on which we as a [illegible] based on experience and long study.

1. The provincial service plan or municipal [illegible] can build for itself the capacity to [illegible] on its own. On us, the medical

profession depends the success or failure of all prepayment services. By the very nature of things this is irrevocably so.

2. High quality medical care, based solely on the evolving science of medicine as taught in the medical faculties of our universities is perfecting itself year by year. Nothing we or anyone else may do should impede this progress or tie its evolution to economic or administrative controls.

3. We, the medical profession must therefore assume the sole responsibility for the control of the quality of care a patient gets. Only those adequately trained in scientific medicine are equipped for this task.

4. We feel equally obligated to protect the needs and rights of our patients for necessary and adequate health services. We must, if necesssry, defend the patient's right for necessary medical services against unwarranted interference of third parties, government or others. The patient as a citizen has the right to choose the type and quality of care from those available to him.

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The patient as a citizen has the right to choose the type and quality of care from those available to him.

5. The same inalienable right by which a patient may choose or reject any treatment offered to him must include his right to provide for his health care on his own terms.

6. On the other hand no health services should be denied anyone because of his inability to finance them. It follows therefore that where necessary both the profession and society must set up whatever mechanisms are necessary to make health services available, but in no instance should the coercive power of the state be used to impose either services or economic systems unless all other mechanisms and approaches fail.

Para. 30 The medical profession of this province freely assumes the responsibility of cooperating in all efforts to meet this problem within the framework of this basic philosophy. We have further developed with our confreres the document filed with you as the Statement of Policy of the Canadian Medical Association on Medical Services Insurance. (Appendix B)

RECOMMENDATIONS

Para.31 Based on these principles and conclusions and in an attempt to promote full utilization of the available medical services we are subsequently proposing a plan (Par. 77 and following) by which all the citizens

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Page 20 The medical profession of this province (Ontario) assumes the responsibility of participating in efforts to seek this problem within the framework of our basic philosophy. We have further developed with our reference the document filed with you as the Statement of Policy of the Canadian Medical Association on Medical Care Insurance. (Appendix B)

RECOMMENDATIONS

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of this province may provide themselves with prepaid medical care insurance. In proposing this plan we would point out that certaun costly services contingent upon illness must be differentiated from each other:

1. Benefits necessary to recovery:

(a) Extra nursing services for the seriously ill.

(b) All drugs medically necessary irrespective of cost.

(c) All paramedical services necessary for diagnosis and treatment of disease -- e.g. Laboratory facilities, physiotherapy.

2. Benefits having no relation to disease or recovery but related to patients economic well being:

(a) Illness income protection.

(b) Disability insurance.

(c) Maternity benefits for working mothers.

3. Luxury benefits:

(a) Semi-private and private accommodation by choice.

(b) Special nursing service, when not medically necessary.

(c) Costly drugs and appliances chosen for luxury reasons.

Para. 32 The medical profession favors as wide a coverage of illness benefits as is economically feasible. Without limiting this statement we suggest:

1. That all services ordered by a physician for the prevention, diagnosis or treatment of disease should be made available in any voluntary prepaid medical services insurance programme.

2. That insurance for luxury services be made available for those able and willing to procure them.

3. Because of the necessity for professional control of the factors affecting the payment of benefits, the profession considers that voluntary agencies should operate extended benefit insurance as supplementary to a comprehensive programme of medical care.

4. That all monies designed to provide physicians' services should be affected favourably or otherwise by any type of paramedical benefits.

5. That the profession has an open mind on matters of co-insurance, and experience rating. Methods of preventing over servicing and controlling costs are desirable.

6. That we do not feel competent to advise whether disability insurance, or benefits for out of work due to illness, should be established under

disease or treatment of cases, should be made available in any voluntary prepaid medical services programme.

2. That insurance for injury services be made available for those sick and willing to pay the dues.

3. Because of the necessity for professional control of the fees allowing the payment of benefits, the profession considers that voluntary insurance should consist exclusively of insurance as a supplementary to a compulsory or compulsory medical care.

4. That all monies designed to provide physicians' services should be allocated into reality or insurance by any type of personal benefits.

5. That the profession has an open mind on medical or co-insurance and supervision rating. Methods of remuneration over per diem and non-profiting costs are desirable.

6. That we do not fear competent in advice whether disability insurance, or benefits for out of work due to illness, should be considered under

or public sponsorship. It would appear that such programmes, as well as maternity benefits for the employed woman, and all such welfare benefits are outside the scope of this enquiry. We feel we should pass them by without comment.

Para. 33 Within the framework of these recommendations and suggestions we believe that self-supporting citizens are willing and should be encouraged to provide themselves with prepaid medical care insurance through an approved health insurance carrier.

Para. 34 We believe that three general groups of the population will require assistance to enable them to provide themselves with prepaid medical care insurance and we are suggesting a mechanism by which this assistance may be made available.

These groups are composed of:

(1) Persons of any age with low income and limited financial means.

(2) Persons uninsurable because of pre-existing disease.

(3) Persons sixty-five years of age and older.

Para. 35 We are convinced that with a well organized educational programme and with the mechanisms suggested to assist these groups, that a high percentage of our population will provide themselves with medical care insurance.

Para. 36 We believe that medical services provided to

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(2) Persons unemployable because of [illegible]

(3) Persons sixty-five years of age [illegible]

Para. 79 [illegible] to assist these groups, need a high percentage of [illegible]

the citizens of this province by private practitioners needs no further elaboration. We have made some recommendations by which the increasing demands for services may be met to a fuller degree by this group and we have outlined the principles underlying our proposed prepaid medical care plan by which we feel fuller utilization of available medical services will be fostered.

HEALTH SERVICES MADE AVAILABLE THROUGH GOVERNMENT AGENCIES

Para. 37 As in other provinces in Canada certain services in this province are administered and financed by the Federal Government. We believe that the existing arrangement for these special groups, such as the Department of Veterans' Affairs, Indians, Immigrants and Sick Mariners, Royal Canadian Mounted Police and Armed Forces has provided satisfactory medical services to those eligible and we recommend that this policy remain unaltered.

GOVERNMENT GRANTS (Appendix "C")

Para. 38 No doubt you will be advised by other bodies of the amounts of federal monies expended to finance various health services in the country, and the projects covered by these grants will be outlined to you. In this province, as a subsequent section of this submission outlines, some $563,000.00 in federal health grants, exclusive of the hospitalization grant was made available last year. The projects covered by these grants have varied from year to year, but in recent years the larger portions have been directed, as is later shown,

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towards Hospital Construction, General Public Health, and Mental Health, with lesser amounts directed to the very important projects undertaken through the Professional Training Grant, Tuberculosis Control Grant, Cancer Control Grant, the Medical Rehabilitation Grant and the Child and Maternal Health Grant.

Para. 39 This association believes that, with the implementation of a Voluntary Health Insurance Scheme such as we are suggesting, or any variation thereof, that in principle these Federal Grants should continue with adjustments as necessary depending upon circumstances from time to time.

Para. 40 In addition to these Federal Grants, Provincial Grants, often on a matching basis, and in some cases Municipal Grants have for some years been directed to various aspects of health care in the province. We would recommend that this arrangement also should continue with modifications where necessary. The projects carried on under the General Public Health Grant are vitally important and must continue. These include, among other undertakings, the work carried on by the Division of Sanitary Engineering, support for the Division of Dental Public Health, and the training of Dental Hygienists, the cost of the laboratory investigation in outbreaks of communicable disease, support for the Division of Venereal Disease Control and other public health measures.

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Para. 60 In addition to these Federal Grants, Provincial Grants, often on a matching basis, and in some cases Municipal Grants have for some years been directed to various aspects of health care in the province. We would recommend that this arrangement also should continue with modifications where necessary. The projects carried on under the General Public Health Grant are vitally important and must continue. These include,

[illegible]

Division of Dental Public Health, and the training of Dental Hygienists; the cost of the laboratory investigation in outbreaks of communicable disease, support for the Division of Venereal Disease Control and other public health measures.

DIVISION OF MENTAL HEALTH (Appendix "D")

Para. 41 In the field of Mental Health, physical facilities are considered adequate for the care of the adult mentally ill. The first unit of a cottage type Hospital-Home for the care of retarded children is now under construction. There exists a need for one or two more such units, as well as facilities for the in-patient care of the adult retarded. There is a growing need for facilities for the in-patient treatment of emotionally disturbed children. Deficiencies exist in the psychiatric services which are available, not only at our mental institution but particularly in our out-patient clinics, exclusive of Child Psychiatry in the Charlottetown area.

Para. 42 In view of the fact that patients in our mental institution in this province are billed on a per diem basis for their hospital care, we believe that this group of people should not be excluded from the benefits of the Hospital Insurance Plan. We would recommend that out-patient psychiatric service be expanded and that the cost to the patient for this service be provided for in a manner similar to that for other medical services. We deplore the factors which have resulted in a very rapid turnover in our psychiatric staff in recent years, and have left us with definite deficiencies in this field.

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We deplore the factors which have resulted in a very rapid turnover in our psychiatric staff in recent years, and have left us with definite deficiencies in this field.

We believe some improvements have been made. We recommend that these factors - administrative or financial - to be corrected.

ALCOHOL AND DRUG ADDICTION (Appendix E)

Para. 43 While drug addiction is a minor problem in this area, alcoholism is a major one, for which at present we have very little in the way of treatment facilities. We recommend that physical facilities be established with adequate staff to properly cope with this problem.

DIVISION OF TUBERCULOSIS CONTROL (Appendix C)

Para. 44 We believe that our present programme for the control and elimination of tuberculosis in this community is producing satisfactory results. After many years with a long waiting list of patients for admission, our Provincial Sanitorium is now running at less than full capacity. We would recommend that this service might be improved by the addition of personnel as follows: one public health nurse, for contact follow-up work and out-patient treatments; one part-time internal medical specialist trained in chest diseases; and one qualified public health educator to assist in the public education aspect of the prevention of tuberculosis.

DIVISION OF CANCER CONTROL (Appendix F)

Para. 45 Services available through this Division consist of:

1. Diagnostic: Consultation service by a certified radiotherapist; anaesthetic, endoscopy, biopsy, and other diagnostic services as indicated.

Para. 43 While drug addiction is a minor problem in this area, alcoholism is a major one, for which at present we have very little in the way of treatment facilities. We recommend that physical facilities be established with adequate staff to properly cope with this problem.

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Para. 45 Preventive Medical Services

Under our Preventive Medical Services we consider:

1. Diagnostic: Consultation service by a qualified

Urology, and other diagnostic services as indicated.

2. Therapeutic: Radiotherapy in appropriate cases.

DIVISION OF LABORATORIES (Appendix G)

Para. 46 This service is established with the main laboratory and administration unit located at the Health Centre In Charlottetown. An affiliated laboratory with one or more registered technicians is located in each of the three major general hospitals while each of the smaller hospitals has a small laboratory staffed by a "Technical Assistant" who is trained to do only the simpler tests.

Para. 47 The work carried out in all these hospital laboratories is under the direction of the senior medical and technical staff of the Division, who are also responsible for the training of student laboratory technologists.

Para. 48 The deficiencies which exist in the service provided by this division along with detailed recommendations for their improvement are contained in the appendix.

BLOOD TRANSFUSION SERVICES (Appendix G)

Para. 49 This service is carried out under the supervision of the director of Laboratories and the centre is located in the same building. This local laboratory is a sub-depot to the Halifax depot and is staffed by two full-time technicians, and is supported by the Red Cross and Hospital Insurance Program. We believe this service satisfactorily fulfills our needs.

DIVISION OF LABORATORIES (Appendix D)

Para. 46 This service is established with the main laboratory and administration unit located at one Hospital or more registered technicians is located in each of the three major General hospitals while each of the smaller hospitals has a small laboratory staffed by a "Technical Assistant" who is trained to do only the simpler tests.

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PROVISION OF BIOLOGICALS (Appendix H)

Para. 50. Under the present arrangement certain biologicals, vaccines, and antiobotics are made available out of tax revenue for the treatment or control of certain diseases. This association recommends that this service be expanded to provide certain other drugs used in some of the chronic diseases where such drugs are necessary to health. e. g.

1. Insulin and Tolbutamide in diabetes.
2. Liver Extract and Viatmin B_{12} in Pernicious Anaemia.
3. Steroids for replacement therapy in Addison's disease.
4. These or other drugs for prolonged therapy where indicated when financial need is demonstraded.

DIVISION OF VENERAL DISEASE CONTROL

Para. 51 This division maintains an office at Charlottetown under a part-time medical director. Although this group of diseases are well under control in this area, we believe that this service must be maintained because of the necessity of a good control program.

REHABILITATION SERVICES (appendix I)

Para. 52 These services are available under two categories:

(1) Rehabilitation for certain chronic disabilites at the Rehabilitation Centre in Charlottetown, which is administered by the Provincial Department of Health.

available out of tax revenue for the treatment or control of certain diseases. This association recommends that this service be expanded to provide certain other drugs used in some of the chronic diseases where such drugs are necessary to health e. g.

1. Insulin and Tolbutamide in diabetes.
2. Liver Extract and vitamin B_{12} in Pernicious Anaemia.
3. Steroids for replacement therapy in Addison's disease.
4. These or other drugs for prolonged therapy where indicated when financial need is demonstrated.

DIVISION OF CERVICAL DISEASE CONTROL

Para. 51 This division maintains an office at Charlottetown under a part-time medical director. Although this group of diseases are well under control in this area, we believe that this service must be maintained because of the necessity of a good control program.

REHABILITATION SERVICES (Appendix I)

Para. 52 These services are available under two categories:

(1) [illegible]

at the Rehabilitation Centre in Charlottetown, which is administered by the Provincial Department of Health.

(2) Rehabilitation of the more acute cases through Units established at each of the three larger general hospitals and included under the Hospital Insurance Program.

Each of the above facilities would appear to be well equipped to meet present demands both from an in-patient and out-patient point of view.

Para. 53 Admissions to the Rehabilitation Centre are on a referral basis from private practitioners and approved by a Medical Assessment Board nominated by the Medical Association and appointed by the Department of Health.

WORKMEN'S COMPENSATION BOARD

Para. 54 This service is administered here, as in other places, by a Board of Directors. A part-time medical director supervises the medical claims and, in general, for many years, a very happy spirit of cooperation has existed between the board and the medical profession. We believe that satisfactory service is being rendered to injured workmen, in this province, entirely by private practitioners on a fee for service basis.

THE HOSPITAL AS AN ELEMENT OF MODERN MEDICAL CARE

(Appendix J)

Para. 55 There are in the province nine general hospitals providing six hundred and thirty-seven active treatment beds with full facilities for the treatment of acute illnesses. The distribution of these beds geographically across the province is satisfactory, with

Units established at each of the three larger

Each of the above facilities would appear to be well equipped to meet present demands both from an in-patient and out-patient point of view.

Para. 3c. Adaptations to the Rehabilitation Centre are on a referral basis from private practitioners and approved by a Medical Assessment Board nominated by the Medical Association and appointed by the Department of Health

Para. 3d. This service is administered here, as in other places, by a Board of Directors. A part-time medical director supervises the medical claims and, in general, for many years, a very happy spirit of cooperation has existed between the board and the medical profession. We believe that satisfactory service is being rendered to injured workmen in this province, entirely by private practitioners on a fee for service basis.

THE "CONTROL AS AN ELEMENT OF MODERN MEDICAL CARE"

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Para. 3f. There are in the province nine general hospitals providing six hundred and thirty-seven active treatment beds with full facilities for the treatment of acute illnesses. The distribution of these beds geographically across the pr

the possible exception of the Summerside area where the development of the Air Force Base has brought about a rather marked increase in the population for this area.

Para. 56 The chronic hospital bed need is not so well filled. At present, one hundred and three chronic care beds are available in addition to thirty beds at the Rehabilitation Centre. However, the geographic distribution of these beds is somewhat unsatisfactory. Some fifty-eight of our one hundred and three chronic beds are located in Prince County, in the western end of the Island, while only forty-five beds are available in the much more densely populated county of Queens and none in the eastern county of Kings.

Para. 57 We would recommend that a redistribution of chronic care beds be brought about to fill this need in the appropriate areas.

Para. 58 At the present time we believe one of our greatest needs is for additional domiciliary or custodial accomodation. This deficiency has no doubt created some backlog of custodial cases occupying chronic or even actue beds. The need in this field, however, is not well defined and further study is required before definite recommendations can be made.

Para. 59 Diagnostic services on either in-patient, or out-patient basis are available at all the general hospitals and are covered under the Hospital and Diagnostic Services Insurance Plan.

Para. 60 Special facilities which are being provided are as follows:

(1) A Cardio-Pulmonary Laboratory located in the

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Para. 60 Special facilities which are being provided are as follows:

(i) A Cardio-Pulmonary Laboratory located in the

Charlottetown Hospital.

(2) Therapeutic radiology services located at the three larger general hospitals.

(3) Rehabilitation facilities at the three larger general hospitals in addition to the Rehabilitation Centre.

(4) Radioactive Isotope Laboratory will be available, in the near future with the completion of renovations at the Prince Edward Island Hospital.

THE HOSPITAL INSURANCE AND DIAGNOSTIC SERVICES ACT

Para. 61 This plan has been in operation in this province since October 1959 and its institution has created little disruption in the pattern of medical practice on the Island.

Para. 62 The plan is administered in this province by an independent Commission which is chaired by a practicing physician and which is responsible to the Lieutenant Governor-in-Council through the Minister of Health. This association has strongly endorsed this administrative arrangement and recommends fully that it be continued.

DRUGS AND APPLIANCES

Para. 63 Under present conditions no provision is made to supply drugs to patients out of hospital; the only exception to this being in the indigent group where private welfare agencies have, in cases of need, provided necessary medication much as they have provided shelter, food and clothing under similar cir-

(c) Rehabilitation facilities at the three larger general hospitals in addition to the Re-

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cumstances to limited numbers.

Para. 64 Some appliances and sick room supplies are available, on a loan basis, from the Provincial Red Cross, while others are available free or at a nominal charge to the patient through the Rehabilitation Centre, the T.B. League, the Canadian Cancer Society, the Polio Foundation, etc.

CORRELATION

Para. 65 We believe the correlation of the recommendations which we have previously made, with existing facilities or services, will not, in most instances, present any difficult problems.

Private Practice

Para. 66 With reference to private practice, our major source of health service, our primary recommendations that the existing pattern of this service be preserved requires only that the doctor-patient relationship remain undisturbed, that the physician's first responsibility must continue to be his patient and not to any third party, and that the principle of fee for service be retained.

Prepaid Medical Insurance.

Para. 67 These conditions are fulfilled in our proposed scheme for voluntary prepaid medical care to be outlined. Furthermore, we wish to point out that the establishment of this proposed plan can readily be correlated with the existing service provided by our medically sponsored Trans Canada Medical Plans member plan, the Maritime Hospital Service Association.

Alcoholism

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Para. 66 These conditions are fulfilled in our proposed scheme for voluntary prepaid medical care to be utilized. Nevertheless, we wish to point out that the acceptance of this proposed plan can readily be correlated with the existing service provided by our medically sponsored Teams Canada Medical Plans member

Alcoholism

Para. 68 Brief mention should probably be made here of our recommendation for the establishment of a well staffed institution for the treatment and control of alcoholism. We fully realize that neither incarceration in penal institutions, nor the services available through medical practitioners, mental institutions, nor voluntary A.A. organizations are adequate to meet this problem. We believe that the institution we propose should incorporate a farm where these people following recovery from their acute episode could have some out-door occupational therapy and where chronic repeaters could be retained and gainfully employed for prolonged periods of readjustment.

Chronic Care Hospitals

Para. 69 We believe that chronic care hospital beds should appropriately be located in close proximity to the acute general hospital and, at the present time, plans are being formulated for the construction of a chronic care unit in conjunction with the Charlottetown Hospital to meet this deficiency in this area.

Para. 70 From these few remarks it is apprent that the correlation of our proposals with existing facilities and services consist mostly of an extension of such facilities.

MEDICAL PERSONNEL REQUIREMENTS (Appendix K)

Para. 71 In the past 10 years some 75 physicians from this province have graduated from Canadian Medical Schools; during this same 10 years, only 44 Canadian Graduates have registered to practice in the province.

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MEDICAL PERSONNEL REQUIREMENTS (Appendix K)

Para. 71 In the past 10 years some 75 physicians from this province have graduated from Canadian Medical Schools; during this same 10 years, only 44 Canadian

The result is that the physician population ratio in the province remains low, 1:1,140. We might speculate that this may partially be due to the low average income of the area, but other factors no doubt bear some influence. There is a relative scarcity of medical administrative posts, and a complete absence of research, teaching and allied positions. This means that a higher percentage of physicians in the province are directly concerned with the care of the sick. In any event we do believe that many of our physicians, especially in rural areas are carrying an excessive work load. Because of this we will endorse any measures which may be undertaken to promote the supply of medical personnel to the rural areas where need exists.

Para. 72 The provision of adequate medical personnel for present and future needs in the provision of health services is a problem concerning which, we believe, special study will be undertaken by the Commission; you will receive much information from such sources as the Canadian Medical Association, the Association of Canadian Medical Colleges, the Royal College of Physicians and Surgeons of Canada and others. However, although no Medical School is located in this province, we do believe that certain principles must pertain if the supply of professional personnel is to be maintained.

Para. 73 In the past, with the development of increasing scientific knowledge, the medical profession has been very cognizant of the importance of continuing

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[illegible]

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Item 12. The provision of adequate medical personnel for present and future needs in the provinces of health services is a problem concerning which we believe, special study will be undertaken by the Commission; you will receive much information on from such sources as the Canadian Medical Association, the Association of Canadian Medical Colleges, the [illegible] Colleges of Physicians and Surgeons of Canada and others. However, although no Medical School is located in this province, we do believe that certain authorities must persist if the supply of professional personnel is to be maintained.

Item 13. In the past, with the development of [illegible] has been very important of the importance of continuing

study, postgraduate education and refresher courses. We believe very strongly that any new pattern of medical care must contain within itself the motivation for such continuing study and certainly must not penalize the physician wishing to do so.

Para. 74 While it is difficult to enumerate the factors which influence a youth in his decision for or against a medical career, there are certain features which we believe do have some definite bearing.

(1) The public image of the physician.
If this image becomes increasingly one of the physician as a hurried haggard individual, with long irregular hours and night work, very little time for recreation, or family or community life, then the image will compare very unfavourably with the business or professional man across the street who works an eight hour day, five and half days a week. Such an image would only be a deterrent to a young man considering a medical career.

(2) The image of scientists, professional, or business people in other fields who work free from administrative restrictions.

(3) The long period of non-remunerative training required.

(4) The increasing cost of such training.

Para. 75 Many of these features are difficult to influence. Perhaps the last would be the easiest, but many University officials believe that increased

[illegible] [illegible] [illegible] [

scholarships have only a minor effect in increasing the number of candidates to a faculty. We believe you will agree that the choice of a career is more commonly made in the youth's dreams andonly later are financial ways and means looked into.

Para. 76 The public image of the physician can also be altered. It follows that the effect on medical student enrollment which third party intervention in medical care will have, will be determined by the nature of such intervention. If it results in compulsion, bureaucracy, and depersonalization of relationships, then the public image of a medical career will deteriorate; it will no longer appeal to the idealistic in our youth.

A PLAN FOR MEDICAL SERVICES INSURANCE FOR THE CITIZENS OF PRINCE EDWARD ISLAND

Para. 77 In proposing such a plan we believe that it must be built upon the principles enumerated earlier in this presentation (paragraphs 32 - 35) and upon those contained in the Statement of Policy of the Canadian Medical Association on Medical Services Insurance (Appendix B). The success of such a proposed plan is contingent upon the existence and development of facilities, services, and conditions as follows:

A. Necessary physical facilities:

(1) General Hospital beds for acute illness to be available as at present.

(2) Beds for chronic illness to be available in all hospitals over 100 beds under same medical

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[illegible]

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(1) General Hospital beds for acute illness to be available as at present.

(2) Beds for chronic illness to be available in [illegible] hospitals over 100 beds under same medical

staff as for acute illness. (paras. 56-57)

(3) Beds for treatment of mental and emotional illness to be made available in the larger general hospitals.

(4) Special Hospital beds for the treatment of tuberculosis to be available as at present.

(5) Special Hospital beds at Riverside and Hillsborough Hospitals to be available as at present.

(6) Beds for Rehabilitation services to continue at present level.

B. Physicians adequate in number and distribution must be available to ensure complete integration of private practice, government programme and voluntary medical services insurance programmes.

C. The Hospital Insurance programme should be developed and perfected without political interference and without undue government restrictions or controls.

D. All residents should have available to them the benefits of any programme, but freedom of choice of coverage should be a prerogative of all citizens who are willing to provide for themselves.

E. Phasing or staging of programmes may be desirable to ensure a satisfactory evolution of a complete service.

F. The sources from which Government contributions are derived shall be as determined by Government.

G. The provision of a medical services prepayment programme, and the provision of a high quality of service is the joint responsibility of citizens,

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F. The sources from which Government contributions are derived shall be as determined by Government.

G. The provision of a medical services programme programme, and the provision of a high quality of service is the joint responsibility of citizens,

of Government, and of the Medical and allied professional groups.

It is, therefore, a basic obligation on each and every citizen, whether needing or providing a service, to bear part of the financial responsibility for medical services insurance. The closest possible cooperation of patients, government and physicians in the acceptance of necessary controls, is required to provide a high quality service at a just and reasonable cost.

Para. 78 In addition to these the following existing services should be maintained and eveloped from time to time as the need arises.

(1) The care of patients in Hospital for Tuberculosis should be a responsibility of the Provincial Department of Health.

(2) Arrangements for medical services now provided by Hospital Services Commission should be continued.

(3) Present arrangements for General Laboratory Services and Pathology should be provided as at present, or as recommended in Appendix G.

(4) Medical services provided through Workmen's Compensation Board should be continued.

(5) Medical services now provided by special arrangement with the Federal Government should be continued under contract as from time to time developed by the parties concerned, e.g., Department of Veterans' Affairs, Indians, Sick

of Government, and of the Medical and allied [illegible]

It is, therefore, a basic obligation on each and every citizen, whether needing or providing a service, to bear part of the financial responsibility for medical service insurance. The closest possible cooperation of patients, Government and physicians in the acceptance of necessary controls, is required to provide a high quality service at a just and reasonable cost.

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(4) Medical services provided through Workmen's Compensation Board should be continued.

(5) Medical services now provided by special arrangement with the Federal Government should be continued under contract as from time to time developed by the parties concerned, e.g., [illegible]

Mariners, Royal Canadian Mounted Police, Armed Forces, etc.

(6) All biologicals and services now provided by the Provincial Department of Health be coordinated, continued, and expanded as recommended in paragraph 50.

(7) Present programme for rehabilitation should be maintained and expanded to provide further service under the coperative efforts of the Rehabilitation Council, the Government, and the Medical Profession.

(8) Cancer Control Programme should be maintained as presently operating.

Para. 79 We believe that any programme of prepaid medical care insurance must include: all benefits not otherwise available as above including:

(a) Complete and comprehensive in and out of hospital services for all acute, chronic and mental illness.

(b) Out of Province medical services on an authorized basis.

By the same token such a program must contain certain exclusions e. g.

(a) All medical or surgical services carried out for reasons other than medical necessity, including purely cosmetic surgery, examination for third parties, e.g., employment, school, insurance, etc.

(b) Paramedical services including drugs, appliances, nursing, dental and refraction

(6) All diagnostic and service now provided by the Provincial Department of Health be coordinated, continued, and expanded as recommended in paragraph 50.

(7) Present programme for rehabilitation should be maintained and expanded to provide treatment service under the cooperative efforts of the Rehabilitation Council, the Government, and the Medical Profession.

(8) Cancer Control Programme should be maintained as presently operating.

Para. 4 We believe that any programme of preventive medical care insurance must include and not exclude or otherwise available as above indicated:

(a) Complete and comprehensive in one unit of complete services for all across Canada in one national scheme.

(b) Out of Province medical services on an authorized basis.

By the same token such a programme must exclude certain [illegible]

(a) All medical or surgical services certain [illegible] clinical purely cosmetic surgery, [illegible] [illegible] injuries, [illegible], employment, [illegible]

[illegible]

apparatus, [illegible], [illegible] and [illegible]

services, transportation, including ambulance and mileage, and out of province transportation should not be provided in the basic contract but left for detailed study and to be made available at a later date if deemed necessary. These could be included in an extended benefit contract sold as supplementary by the carrier.

Para. 80 We propose that this Medical Services Insurance should be provided and administered by Voluntary Carriers with the following qualifications:

(1) They should be registered with the Department of Insurance of the province.

(2) They must be prepared to provide benefits not less than those defined to be the basic minimum conforming with the above standards, and this contract must be made available to all the people, individuals as well as groups.

(3) They must be willing to have their records subject to an independent annual audit and must get annual approval by the Prince Edward Island Division of the Canadian Medical Association as well as the Government.

(4) They must be prepared to meet the requirements of the section on financing which follows.

FINANCING

Para. 81 Two alternative methods of financing such a plan are available:

(1) All persons of the community are pooled as a

[illegible]

[illegible]

should not be provided in the basic contract but left for detailed study and to be made available at a later date if deemed [illegible]. These could be included in an [illegible] contract sold as supplementary by the carrier.

Para. 80 We propose that this Marine Insurance should be provided and administered on Voluntary Carriers with the following qualifications:

(1) They should be registered with the Department of Insurance of the province;

(2) They must be prepared to provide coverage on less than those defined to be the basic minimum coverage with [illegible], and this coverage must be made available to the people, individuals as well as groups;

(3) They must be willing to have their [illegible] subject to an independent annual audit and must get annual approval by the Private Insurance Division of the Canadian Medical Association as well as the Government;

(4) They must be prepared to meet the requirements of the [illegible] on Insurance which is [illegible].

Para. 81 Two alternative methods of [illegible]

single group risk - that is all ages, the sick, the well, the infirm, and the uninsurable. A community rate is struck for the total population. We would favor this community rating method because:

(a) It puts the burden where it belongs-on the whole community.

(b) It obviates difficult classifications.

(c) It is simple to operate and cheaper to administer.

(d) It is now in use for the Hospital Services Insurance Plan.

(2) Alternatively the population is divided into groups and each one is experience rated. This makes premiums for certain categories prohibitively expensive and does not spread risk adequately.

Para. 82 In such a plan we propose that:

(1) Self supporting citizens pay their own premium.

(2) Those unable to do so should have their premiums paid by Government.

(3) Certain others might require and receive assistance in meeting part of the premium cost.

Para. 83 In proposing a method of physician remuneration we submit that this be on a fee for service basis based on the Schedule of Fees of the Prince Edward Island Division of the Canadian Medical Association. We wish to indicate, however, that this Association is

single group risk - that is all ages, the sick, the well, the infirm, and the uninsurable. A community rate is equal for the total population. We would favor this community

(a) It puts the burden where it belongs - on the whole community.

(b) It avoids difficult classification

(c) It is simple to operate and economical

(d) It is now in use for the Hospital Service Insurance Plan.

(2) Alternatively the population is divided into groups and each one is experience rated. This makes premiums for certain groups prohibitively expensive and does not provide

Para. 4: In such a plan we propose that:

(1) Self supporting citizens pay their own premium.

(2) Those unable to do so shall have their premiums paid by Government

(3) Certain others might require and receive assistance in meeting part of the premium cost.

Remuneration we submit that this be on a fee for service basis based on the schedule of fees of the Private

willing to negotiate special terms for those groups for whom the Government pays the premium.

Para. 84 The schedule of fees must remain subject to periodic revision by the Prince Edward Island Division of the Canadian Medical Association and we would suggest, in an attempt to insure that it remain fair and equitable, that, within reasonable limits, it maintain the same relationship to the cost of living index, as it now bears.

Para. 85 While the precise cost of all medical services presently being provided to the citizens of this province is rather difficult to accurately assess, we do not have some definite information upon which we can base our estimates of the cost of providing health services according to the plan which we have recommended. A review of the stastistics of the Maritime Hospital Services Association indicates that the per capita cost of such a plan as is proposed would be in the vicinity of $20.00 annually. This estimate is considered to be realistic by the Maritime Hospital Services Association. Based on this figure the total cost of this plan for all the people of this province would be slightly over $2,000,000.00. Based on the experience of our Provincial Hospital Services Plan, it is estimated that 10% of our population are financially unable to pay such premium.

Assuming that government would be responsible for this group, the cost to government would be approximately $200,000.00 annually. It is further estimated that an additional 20% of our population might

[illegible]

[illegible]

[illegible]

to periodic review by the Prince Edward Island Division of the Canadian Medical Association and we would suggest, in an attempt to insure that a [illegible] fair and equitable, that, within reasonable [illegible] maintain the same relationship to the cost of living index, as it now exists.

Para. 82 While the average cost of all medical services presently being provided to the citizens of this province is rather difficult to ascertain, [illegible] we do not have some definite information upon which we can base our estimates of the cost of [illegible] health services according to the plan [illegible] recommended. A review of the expenditures of the Maritime Hospital Services Association [illegible] the per capita cost of such a plan as is presently being [illegible] in the vicinity of $20.00 annually. This estimate is considered to be realistic by the Maritime Hospital Services Association. Based on this figure the cost of this plan for all the people of this province would be slightly over $2,000,000.00. Based on the experience of our Provincial Hospital Services Plan it is estimated that 75% of our population are financially unable to pay such premiums.

For this group, the cost to government would be approximately $500,000.00 annually. It is [illegible] estimated that an additional 10% of our population [illegible]

be able to meet an estimated 50% of the premium cost only. This then would mean another $200,000.00 annual cost to government or a total of $400,000.00 per year while the remaining $1,600,000.00 would be the responsibility of self supporting citizens.

Para. 86 We submit that some of the advantages of such a plan are:

(1) All good existing services are utilized.

(2) All persons share the burden as proportionately as possible.

(3) Contributions by employers are not interfered with, and all union negotiated contracts remain intact.

(4) The rights of citizens are protected in choice of plan, service, and physician.

(5) No Government or political interference is demanded, implied, or possible. Efficiency can be critically analyzed by all parties.

(6) The cost of taxpayers is kept at the absolute minimum.

(7) The cooperation of those receiving and those giving the service is ensured and the role of Government to protect citizens' interests is not influenced by undue and reasonable pressures.

(8) No part of this plan is irrevocable since it is not embodied in legislation. As medical services insurance evolves, adaptations are easy to make to comply with new situations.

(9) Controls by government, the profession and the carrier, absolutely essential to the operation

be able to meet an estimated [illegible] at the premium [illegible] only. This then would mean another [illegible] while the remaining $4,000,000.00 would be the responsibility of self supporting citizens.

Para. 35 We submit that some of the advantages of [illegible]

(1) All good existing services are utilized.

(2) All persons where the burden is [illegible] as possible.

(3) Contributions by employers are [illegible] with, and all union negotiation [illegible] main issues.

(4) The rights of citizens are [illegible] of plan, service, and benefits.

(5) No governments or politicians [illegible] damaged, modified, or penalized [illegible] can be seriously analyzed by a [illegible].

(6) The cost of taxpayers is kept at the [illegible] minimum.

(7) The cooperation of those negotiating and [illegible] giving the service in [illegible] and the [illegible]

(8) No part of this plan is irreversible since it [illegible] or amended in legislation. As medical services insurance evolves, adaptations [illegible] easily to meet be comply with new [illegible]

(9) Controls by government, the profession and the carrier, seemingly seemingly to be [illegible]

of any such plan, can be effectively set up to prevent over utilization, excessive servicing,and also to keep costs at correct levels.

(10) Medical Services costs and Hospital Services costs are kept separated.

Para. 87 We believe that this proposal to provide prepaid medical care to the citizens of Prince Edward Island is practical and economically feasable and avoids throwing excessive burden upon individuals, groups or government.

PRIORITIES

Para. 88 Priority in the establishment of the different aspects of improved health services has already been referred to. We believe the correction of the deficiencies noted in services provided or underwritten by Government, and particularly those in the field of Mental Health should receive prior attention.

We would urge that studies be completed at an early date to define clearly the chronic care and custodial bed requirements of the different general areas. We would recommend that the implementation of the proposed voluntary prepaid medical insurance plan be initiated and that necessary in and out of hospital medical benefits only be included in the initial stages.

Respectfully submitted,

Honorable L.G.Dewar M.D., President

C. A. Coady M.D., Honorary Sec'y.
Prince Edward Island Division
Canadian Medical Association.

[illegible]

Para. 97 We believe that this proposal to provide prepaid medical care to the citizens of Prince Edward Island is practical and economically feasible and avoids throwing excessive burden upon individuals, groups or governments.

Para. 98 Pending an the actual implementation of the different aspects of improved health care [illegible] already been realized [illegible] of the deficiencies noted in previous proposal [illegible] implementation by government, and particularly [illegible] the field of dental health [illegible]

We would urge that consideration be [illegible] early date to define clearly the objectives [illegible] coordinated and responsibilities of the different government areas. We would recommend that the implementation of the proposed voluntary prepaid medical insurance plan be initiated and that necessary [illegible] and out of hospital medical benefits may be included in the [illegible]

Respectfully submitted.

Respectfully [illegible] G. Power M.D., F.C.P.

C. A. Young, M.D., Honorary Pres. Prince Edward Island Med. [illegible]

APPENDIX X

PHYSICIAN DISTRIBUTION

Number of Physicians in private practice and type of work done:

	Charlottetown	Summerside	Other Areas	Total
1. General Practitioners	11	8	25	44
2. Specialty Practice -				
Internal Medicine	3	1	0	4
General Surgery	5	3	2	10
Obstetrics & Gynecology	4	1	0	5
Anaesthesiology	2	1	0	3
Psychiatry	1	0	0	1
Paediatrics	2	0	0	2
Ophtholmology	2	0	0	2
Otolaryngology	2	0	0	2
Urology	1	0	0	1
Radiology	1	0	0	1
Orthopaedics	1	0	0	1
Radiotherapy	1	0	0	1
TOTAL	24	7	2	33

3. Salaried Physicians with type of work done (full-time):

Pathology	2
Mental Health	3
Public Health	2
T. B. Control	[illegible]
Medical Advisory Hospital Commission	1
Department Veteran's Affairs	2
TOTAL	13
GRAND TOTAL	[illegible]

Number of Physicians in private practice and type of work done:

	Total	[illegible]	[illegible]	[illegible]
1. General Practitioners	11	[illegible]	[illegible]	[illegible]
2. Specialty Practice				
Internal Medicine	3	1	[illegible]	
General Surgery	2	3	2	[illegible]
Obstetrics & Gynecology	4	1	[illegible]	
Anesthesiology	2	1	[illegible]	
Psychiatry	1	[illegible]	[illegible]	
[illegible]	[illegible]			
Opthalmology	[illegible]	[illegible]	[illegible]	
Otolaryngology	[illegible]	[illegible]	[illegible]	
[illegible]	[illegible]			
Radiology	[illegible]	[illegible]	[illegible]	
Orthopaedics	[illegible]	[illegible]	[illegible]	
[illegible]	[illegible]			
TOTAL	24	[illegible]	[illegible]	[illegible]

3. Salaried Physicians with type of work done [illegible]

Pathology

Mental Health

Public Health

T. B. Control

Medical Advisory Board [illegible]

Department Veterans Affairs

[illegible]

APPENDIX B

The Canadian Medical Association Statement on Medical Services Insurance:

" The Canadian Medical Association believes that:

The highest standard of medical services should be available to every resident of Canada.

Insurance to prepay the costs of medical services should be available to all regardless of age, state of health or financial status.

Certain individuals require assistance to pay medical services insurance costs.

The efforts of organized medicine, governments and all other interested bodies should be coordinated towards these ends.

While there are certain aspects of medical services in which tax-supported programs are necessary, a tax-supported comprehensive program, compulsory for all, is neither necessary nor desirable.

The Canadian Medical Association will support any program of medical services insurance which adheres to the following principles:

1. That all persons rendering services are legally qualified physicians and surgeons.
2. That every resident of Canada is free to select his doctor and that each doctor is free to choose his patients.

[illegible]

The Canadian Medical Association [illegible]

Services Insurance:

" The Canadian Medical Association believes that the highest standard of medical services should be available to every resident of Canada.

Insurance to prepay the costs of medical services should be available to all [illegible] regardless of age, state of health or financial [illegible]

[illegible]

any medical monopoly. Insurance [illegible] the efforts of compulsory medicine, [illegible] wards and all other [illegible] should be considered [illegible] evils.

While there are certain [illegible] medical services in which, [illegible] programs are necessary, a [illegible] comprehensive program, compulsory for all, is neither necessary nor desirable.

The Canadian Medical Association will support any program of medical services insurance which adheres to the following principles:

1. That all persons rendering services are legally qualified physicians and surgeons.

2. That every resident of Canada is free to select his doctor and that each doctor is free to choose his [illegible]

---

3. That the competence and ability of any doctor is determined only by professional self-government.

4. That within his competence, each physician has the privilege to treat his patients in and out of hospital.

5. That each individual physician is free to select the type and location of his practice.

6. That each patient has the right to have all information pertaining to his medical condition kept confidential except where the public interest is paramount.

7. That the duty of the physician to his individual patient takes precedence over his obligations to any medical services insurance programs.

8. That every resident of Canada, whether a recipient or provider of services, has the right of recourse to the courts in all disputes.

9. That medical services insurance programs do not in any way preclude the private practice of medicine.

10. That medical research, undergraduate and post-graduate teaching are not inhibited by any medical services insurance program.

11. That the administration and finances of medical services insurance programs are completely separate from other programs, and that any board, commission or agency set up to administer any medical services insurance program has fiscal authority and autonomy.

12. That the composite opinion of the appropriate body of the medical profession is considered and the medical profession adequately represented on any

3. That the competence and ability of any doctor to [illegible] by medical [illegible]

4. That without [illegible] privilege to treat his patients in any [illegible] of hospital.

5. That each individual physician is free to select [illegible] type and location of his practice.

6. That each patient has the right to have all information pertaining to his medical care [illegible] confidential except where the public interest [illegible] paramount.

7. That the duty of the physician to his individual patient takes precedence over his obligations to any medical services insurance programme.

8. That every resident of Ontario, whether [illegible] or provider of services, has the right [illegible] choose to be covered in all disputes.

9. That medical services insurance programs in no way preclude the private practice of medicine.

10. That medical research, undergraduate and post-graduate teaching are not affected by any medical services insurance programs.

11. That the administration and financing of medical [illegible] from other programs, and that any [illegible] or agency set up to administer any medical services insurance programs has fiscal authority and [illegible]

12. That the cooperative opinion of the appropriate [illegible] of the medical profession is [illegible] medical profession adequately represented on any

board, commission or agency set up to plan, to establish policy or to direct administration for any medical services insurance program.

13. That members of the medical profession, as the providers of medical services, have the right to determine the method of their remuneration.

14. That the amount of remuneration is a matter for negotiation between the physician and his patient, or those acting on their behalf; and, that all medical services programs make provision for periodic or automatic changes in remuneration to reflect changes in economic conditions."

[illegible] ...tion or agency set up to plan, to [illegible] or to direct administration in [illegible]

[illegible] in [illegible]

providers of medical services, have the right to determine the method of their remuneration.

14. That the amount of remuneration is a matter for negotiation between the physician and his patient or those acting on their behalf; and, that all medical services programs make provision for periodic or automatic changes in remuneration to reflect changes in economic conditions."

APPENDIX C

1. Health Care Assisted Financially by the Federal Government Under National Health Grants.

Since the inception of this program of matching and non-matching grants by the Federal Government in 1948, this province has taken advantage of the money thus made available. The total amount of moneys made available by the Federal Government during the fiscal year 1960-61 amounted to $562,991.

On April 1, 1961, the following changes in the allocation of moneys were effected: (1) Veneral Disease Control Grant and the Laboratory and Radiological Services Grant were eliminted. (2) Crippled Children's Grant was combined with that of Medical Rehabilitation. (3) Tuberculosis Control Grant and the Child & Maternal Health Grants were markedl. descreased. (4) The Professional Training Grant, the Mental Health Grant, the General Public Health Grant, Cancer Control Grant, and the Medical Rehabilitation Grant were increased. The net result was an overall increase of $33,877 over the allocation of the previous year. However, the regulations governing the Health Grants were also changed by Minute-in Coundil requiring the province to contribute an amount proportionate to the Provincial expenditures in 1959-60 on all projects before Federal assistance was available. In several of these fields the province has already been contributing substantially to programs which became insured services during the last six months of the fiscal year and the

ment in 1948, this province has taken advantage of the money thus made available. The total amount of money made available by the Federal Government during the fiscal year 1950-51 amounted to $[illegible],000.

On April 1, 1951, the following changes in the allocation of moneys were effected: (1) Venereal Disease Control Grant and the Laboratory and Radiological Services Grant were eliminated. (2) Crippled Children's Grant was combined with the Medical Rehabilitation. (3) Tuberculosis Control Grant and the Child & Maternal Health Grant were merged; diseases. (4) The Professional Training Grant, the Mental Health Grant, the General Public Health Grant, Cancer Control Grant, and the Medical Rehabilitation Grants were increased. The net result was an overall increase of $33,077 over the allocation of the previous year. However, the regulations governing the Health Grants were also changed by Minister-in Council, requiring the province to contribute an amount proportionate to the provincial expenditures in 1950-51 on all programs before Federal assistance was available. In several of these fields the province has already been [illegible] sufficiently to programs which become [illegible] during the last six months of the fiscal year, and the

result, therefore, has been detrimental to the interests of this province in that in order to obtain the full Federal contribution a larger total contribution was required from the provincial sources.

Professional Training Grant

This amounted to $19,596. This grant was used to provide training in the following areas:
(1) To assist in completion of training of a pharmacist for the Prince Edward Island Hospital. (2) To assist in the study of Hospitals Councils in Saskatchewan by a member of the Hospital Services Commission. (3) To provide special training of a technician for the Cardio-Pulmonary Laboratory in the Charlottetown Hospital (4) To assist in providing a short course in special techniques used in the training of crippled children provided to a teacher employed for retarded children classes. (5) To assist in the completion of training of a Public Health Nurse.

Hospital Construction Grant -- $101,477 plus a Revote of $103,802.75.

For the fiscal year 1960-61 this Grant provided as follows:
$30,266 -- representing the entire contribution toward the cost of renovations at the Charlottetown Hospital, including the construction of a tunnel entrance from the new Nurses' residence, addition of a second passenger elevator, provision of a cafeteria and cold storage facilities.
$35,166 -- as the first fifty percent of the project for renovations at the Prince Edward Island Hospital,

Federal contribution a larger total construction [illegible]

Professional Training Grant

This amounted to $[illegible]. This grant [illegible]

(1) To assist in completion of training of a [illegible] for the Prince Edward Island Hospital. (2) [illegible] in the study of Hospitals Community in [illegible] a member of the Hospital Services Commission. (3) To provide special training of a technician for the Radio-Pulmonary Laboratory in the [illegible] (4) To assist in providing a short course in special techniques used in the training of surgical [illegible] provided to a teacher employed for [illegible] classes. (5) To assist in the completion of training of a Public Health Nurse.

Hospital Construction Grant -- $[illegible] plus a [illegible]

For the fiscal year 1[illegible] [illegible] were provided as follows:

$30,266 -- representing the capital [illegible] on [illegible] the cost of renovations at the [illegible] including the construction of a [illegible] corridor, the new nurses residence, addition of a second passenger elevator, provision of a cafeteria and food [illegible] facilities

$55,166 -- as the first fifty percent of the project

including expansion of the laboratory and radiological facilities, expansion of office space, creation of a new paediatric department, provision of facilities for long term and convalescent care and other minor alterations.

$81,420 -- as a complete payment toward an addition at Western Hospital, Alberton, involving twenty-two beds, new operating and delivery suits, newborn nursery, expanded laboratory, radiological and emergency facilities, as well as additional administrative space and Nurses Residence of fourteen beds. In addition an amount of $13,147 toward the cost of renovation in the existing building at Western Hospital is expected to be claimed.

$7,025 -- as a complete payment to Community Hospital, O'Leary, for renovations involving the installation of an elevator, an emergency ambulance entrance and improved out-patient facilities.

Mental Health Grant -- $74,749.

This amount was inadequate to meet the requirements of the various projects in this field. These projects include the full cost of operation of the Mental Health Clinics in Charlottetown and Summerside, the expenses of bringing consultant psychiatrists from the Teaching Centre at Dalhousie University each month, and consulting services of visiting neurologist.

At the Mental Hospitals, projects under this grant include the salaries of all physicians except the Director, together with the full cost of operation of the occupational therapy unit, the expense of carrying out lobotomy operations, support of the provincial share of the operating cost of post-graduate schools in

including ex[illegible]

pediatric department, provision of facilities for long

$81,420 -- as a complete payment toward an addition at

new operating and delivery suite, new-born nursery,

expanded laboratory, radiological and emergency facilities

as well as additional rehabilitative space and future

Residence of Fourteen beds. In addition an amount of

$13,147 toward the cost of renovation in the existing

building at Western Hospital is approved to be offset

$7,025 -- as a complete payment to Commander Thomas

O'Beary, for renovations [illegible] and installation of

an elevator, an emergency [illegible]

improved out-patient facilities.

Mental Health Grant -- $[illegible],[illegible]

This amount was [illegible]

payments of the various projects [illegible]

These projects include the full cost of [illegible] of the

mental health clinics in Owen Sound and [illegible]

the expenses of [illegible] consultant psychiatrist [illegible]

the Teaching Centre at Bellevue [illegible]

and consulting services of visiting psychologist.

At the Kenai Hospital, projects [illegible]

grant include the salaries of all psychiatrists except

the Director, together with the full cost of operation

of the occupational therapy unit, the expense of a [illegible]

Psychiatry, Psychology and Social Work, and include the cost of tuition, books, travel and a monthly stipend toward the training of psychiatric social workers, guidance consultants, and speech therapists.

Tuberculosis Control Grant -- $29, 557

This grant has been reduced to sixty percent of the former amount and is quite inadequate to meet the projects which include the cost of operating out-patient chest clinics, one-third of the salary of the physician in charge of treatment of bone and joint tuberculosis at the Rehabilitation Centre and the cost of special drugs used in treating selected cases of tuberculosis, as well as a substantial contribution toward the cost of the tuberculin testing and x-ray program carried out in conjunction with the Prince Edward Island Tuberculosis League.

General Public Health Grant -- $128,579

This grant was increased by over $78,000 and is now more than adequate to meet the projects submitted under it in 1960-61, including the entire cost of operating the Division of Sanitary Engineering (excluding a small amount for general office expenses); similar support for the Division of Dental Public Health, but excluding the maintenance of clinics in Charlottetown and Summerside; support of the cost of operating the postgraduate School of Nursing at Dalhousie University; a grant to the Association of Nurses of Prince Edward Island to assist toward paying the salary of a School of Nursing Advisor; rental of clinic space and provision of clerical staff at the Health Centre in

This grant has been reduced to sixty percent of the former amount and is quite inadequate to meet the projects which include the cost of operating out-patient chest clinics, one-third of the salary of a physician in charge of treatment of bone and joint tuberculosis at the Rehabilitation Centre and the cost of special drugs used in treating selected cases of tuberculosis, as well as a supplemental contribution toward the cost of the tuberculin testing and x-ray programme carried out in conjunction with the Edward Island Tuberculosis League.

General Public Health Grant - 1950-51:

This grant was increased by over $4,000 and is now more than adequate to meet the projects available under it in 1950-51, including the entire cost of operating the Division of Sanitary Engineering (including a small amount for general office expenses); similar support for the Division of Rural Public Health, including providing the maintenance of clinics in Charlottetown and Summerside; support of the cost of operating the postgraduate School of Nursing in Halifax; a grant to the Association of Nurses of Prince Edward Island to assist toward paying the salary of a Director of Nursing Advisor; rent of clinic space; the provision of clerical staff at the Health Centre in

Summerside serving the Western half of the Province; the cost of laboratory investigation in connection with outbreaks of communicable diseas throughout the Province, to control hospital infections; support of the cost of maintaining the Division of V.D. Control; training of Dental Hygienists; small grants to assist the cost of accrediting Canadian hospitals and to provide a technical advisory service to the Department; a six weeks course in teaching methods provided to three Nurse Supervisors from general hospitals; sponsoring a Director of Nursing for a degree course in Nursing; five other Nurse Supervisors, Teachers, and Clinical Instructors were sponsored in courses of Administration and Nursing Education. Total cost of projects under this grant amounted to about $100,000

Cancer Control Grant -- $29,864

The grant sponsored the completion of training of the Director of the Division in dianostic radiology. It also provided support toward the cost of operating the Division and employing professional services to investigate cases suspected of having cancer at no direct cost to the patient.

Medical Rehabilitation and Crippled Children - $24,747

This grant supported the training of a physiotherapist who is now employed at the Rehabilitation Centre and an Occupational Therapist who is employed also; also a bracemaker who has been employed since January 1, 1961. It also provided fifty percent of the cost of poliomyelitis vaccine used in protecting children in this Province.

[illegible] serving the Western half of the Province, [illegible] with outbreaks of communicable disease throughout the Province, to control hospital infections, reports on [illegible] training of Dental Hygienists; and/ [illegible] the need of accredited Canadian hospitals can be provide a technical advisory service to the Department. a six weeks course in teaching such as provided to three Nurse Supervisors from general hospitals; sponsoring a Director of Nursing for a degree course in Nursing; five other Nurse Supervisors, Teachers, and clinical instructors were assisted in courses of administration and Nursing Education. [illegible] programs under this [illegible]

The grant supported the employment of [illegible] of the Director of the Division of Mental [illegible] I also provided support towards the cost of supporting the Division and employing professional services to investigate cases, inspection of hospitals, [illegible] at no direct cost to the province.

Medical Rehabilitation and Chronic Medicine - $[illegible]

This grant supported the employing of a physiotherapist who is now employed at the Kansas Health Centre and an Occupational Therapist who is employed also; also a dressmaker who has been employed since [illegible]. It also provided [illegible] of the cost of polimyelitis vaccine used in [illegible] children in this Province.

Child and Maternal Health Grant -- $20,209

The use of this grant has been severely restricted since the resignation of the nurse in charge of this program in 1959, and the introduction of the Provincial Hospital Insurance Plan in 1959. However, one nurse was employed full-time to carry out Child and Maternal Health work in the Summerside area, the cost being covered under this grant. In addition, the rental of four health nursing offices which serve as centres for Child and Maternal Health Programmes was paid for by the grant. It also supported a post-graduate course in paediatrics for one Nurse Supervisor and provided a two weeks course in Public Health Nurses and nurses from general hospitals in Maternal and Child Health.

2. Public Health Services Provided by Provincial Government

(1) Public Health Nursing

The Division of Public Health Nursing, employing some fifteen nurses, carried out a comprehensive program of health education and preventive health services in the homes and schools of the province. Maternal prenatal classes are held in three centres and some two hundred and thirty two visits were made to expectant mothers in their homes. Most primipara are visited at home within two weeks of their discharge from hospital, and advice is given on maternal and infant care. Visits are also made in connection with health problems of preschool children and this is followed up by regular health inspections in the schools.

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

one nurse was employed full-time to carry on Child and Maternal Health work in the Summerside area, for cost being covered under the grant. In addition, the rental of four health centres [illegible] centres for Child and Maternal Health Programmes has been paid for by the grant. It also supported a [illegible] graduate course in pediatrics for one Nurse-Supervisor and provided a two weeks course in Public Health Nurses and nurses from general hospitals in Maternal and Child Health.

d. Public Health Services provided by [illegible]

(i) Public Health Nursing

The Division of Public Health Nursing [illegible] programs of health education and preventive health services in the homes and schools of the province. Maternal, preventable diseases are held in three centres and some two hundred and thirty two visits were made to expectant mothers in their homes. Most primiparas are visited at home within two weeks of their discharge from hospital, and advice is given on maternal and infant care. Visits are also made in connection with health problems of pre-school children and this is followed up by regular health inspections in the schools.

Public Health Nurses conduct the program of inoculations for infants, pre-school and school children against Diphtheria, Whooping Cough, Tetanus, and Polio. In the year 1960, twenty-six thousand nine hundred and eighty-three children were inoculated, fourteen thousand seven hundred and fifty-nine persons received Polio vaccine, and ten thousand two hundred and twenty-one persons received Smallpox vaccine. In addition, Public Health Nurses carry out follow-up visits to tuberculosis cases discharged from Sanatorium, assist in regional Chest Clinics and in the province-wide tuberculin testing program. They also do much of the formal health education for the Department, addressing some seven hundred and forty-two groups in 1960.

(2) Sanitary Engineering

Though handicapped by lack of a qualified Sanitary Engineer to serve as Director, this Division provides all the Public Health sanitation services for the province. It supervises the operation of all pasteurization plants through weekly sampling and inspection. All tourist accomodations are inspected on repeated visits and advice is given on improvements to meet an acceptable standard. Eating establishments, hospitals and public institutions are inspected at frequent intervals and every effort is made to insure adequate cleanliness in the preparation and storage of foods. A water supply and sewage disposal inspection service is provided to all residences and business establishments in the Town Planning Areas, to schools and

[illegible]

[illegible]

[illegible]

to individuals in any part of the province. Complete sanitary surveys involving both water supply and sewage disposal were completed in three villages and one town in 1960. Periodic sampling of the water supplies of the larger urban centres, of the National Park area and of all provincial parks is carried out. In addition, all plans for new public sewers and extension to existing sewers must be approved by the Division. Other duties of the Division involve supervision over sanitation of summer camps, public bathing beaches, trailer courts and garbage dumps. A Public Health Veterinarian attached to the Division supervises the handling of raw milk supplied to pasteurization plants, conducts a Mastitis Control Program in dairy herds, and inspects slaughter houses with a view to improving sanitary conditions.

(3) Dental Public Health

(a) Dental treatment services through a mobile unit as well as by dentists in their own offices provided treatment to pupils in Grades I and II in various parts of the province. During the year, the total number of children from rural areas who obtained treatment amounted to one thousand two hundred and seventy-one.

(b) Orphanages: Complete treatment services are made available by the Division to all children in orphanages on an annual basis. Clinics in both Charlottetown and Summerside provided treatment to needy children up to the ages of twelve and a total of four hundred and ten children received services in 1960.

[illegible]

sewage disposal were completed in three villages and one town in 1960. Periodic sampling of the water supplies of the larger urban centres, of the Marions Lake area and of all prevalent pests is carried out. In addition all plans for new public sewers and extensions to existing sewers must be approved by the Division. Other duties of the Division involve supervision over [illegible] and garbage dumps. A Public Health Veterinarian attached to the Division supervises the handling of the milk supplied to pasteurization plants, operates a Rabbit Control Program in Grand Bruce, and inspects slaughter houses with a view to improving [illegible].

(3) Hospital Fund

(a) Dental treatment service [illegible] part as well as by assistance in kind and [illegible] vided treatment to pupils in Grades 1 and 2 in various parts of the province. During the year, the [illegible] number of children from rural areas who [illegible] treatment amounted to one thousand two hundred and [illegible]

[illegible] made available by the Division to all children [illegible] employed on annual basis. Clinics in Lake Cheriton, Cheriton and Summerside provide treatment to [illegible]

In addition to this, about one thousand children received Stannous-Fluoride applications during the summer months. A preventive Orthodontic Clinic has been established as a consultative service to practicing dentists and over one hundred children received consultation and treatment services in 1960.

(4) Tuberculosis Control

The Provincial Sanatorium, Charlottetown, in which is located the offices of the Director of Tuberculosis Control and the Business Administrator for the Division serves as a nucleus for the Tuberculosis Control programme on Prince Edward Island.

The sole executive control and management of the Division of Tuberculosis Control, including the operation of the Provincial Sanatorium is vested in the Minister of Health, to whom the Director of the Division is responsible.

A. Provisions and Methods of Personal Health Services

1. Prevention

(a) Education

Of paramount importance in the preventive program is the education of the public in up-to-date trends in the disease, tuberculosis. In this regard, the role of the voluntary agency, the Prince Edward Island Tuberculosis League, in our province, has given excellent service in informing the general public and the professions, regarding tuberculosis.

(b) B.C.G. Vaccination

B.C.G. Vaccination on Prince Edward Island is

In addition to this, about one thousand children

summer months. A preventive Orthopaedic Clinic has been established as a consultative unit to provide dentists and over one hundred children received treatment and treatment services in 1960.

(h)

The Provincial Sanatorium, Qualicum, in which is located the offices of the Division of Tuberculosis Control and the Training Schools for the Division serves as a nucleus for the Tuberculosis Control programme on Prince Edward Island.

The sole executive control and management of the Division of Tuberculosis Control, including the operation of the Provincial Sanatorium is vested in the Minister of Health, to whom the director of the Division is responsible.

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(b) B.C.G. Vaccination

B.C.G. Vaccination on Prince Edward Island

limited to negative tuberculin reactors in certain groups, i. e., Student Nurses and other personnel in general hospitals and at the Sanatorium, to contacts of active cases and other groups in highly tuberculinized areas.

(c) Checking of Contacts

Every active case of tuberculosis diagnosed is immediately reported to the Division of Public Health Nursing, who carry out Tuberculin Testing and refer all positive reactors and older contacts to one of the Out-Patient Diagnostic Clinics.

(d) Tuberculin Testing (Heaf Method) of school attenders

By finding the positive reactors among this group, clues to cases of infectious tuberculosis among families are obtained and those showing radiological evidence of early disease are placed under treatment; in many instances, positive reactors under the age of 10 years are placed on prophylactic I.N.H. therapy.

2. Diagnostic Services

These services include:-

(a) Regular Out-Patient Diagnostic Clinics

These clinics are under the direction of a full-time medical Director of Out-Patient Clinics who received special training in chest diseases. Clinics are regularly held at five focal points in the Province, (Sanatorium, Charlottetown twice weekly; Health Centre, Summerside -- twice monthly; and at the general hospitals in Souris, Montague and Alberton -- once monthly).

limited to negative tuberculin reactors in school groups, i. e., Student Nurses and other personnel in general hospitals and at the same time to contacts of active cases and other groups in highly tuberculinized

is immediately reported to the Division of Public Health Nursing, who carry out Tuberculin Tests, and refer all positive reactors and other contacts to one of the Out-Patient Diagnostic Clinics.

(d) Tuberculin Testing (Heaf method) of school

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in many instances, positive reactors under the age of 10 years are placed on prophylactic I.N.H. therapy

Some medical Director of Out-Patient Clinics has received special training in chest diseases. Clinics are regularly held at five focal points in the Province (Sanatoria, Consultation Clinic weekly; Health Centre Summerside -- twice monthly and in the general hospitals in Sorrie, Montague and Alberton -- once monthly).

(b) Examination of Pensioners, Other War Veterans and Screening of Miniature Admission Chest X-rays in General Hospital

(c) Tuberculin Testing and X-Ray Surveys

Tuberculin Testing utilizing the "Heaf" Method with on-the-spot x-raying of all positive reactors was initiated on a community-wide basis in August, 1956, and has been carried on since. Periodic surveys are also carried out on all school teachers, patients and staff of provincial institutions, students at the College and University, and various industrial groups.

3. Treatment

Complete treatment services are available at the Provincial Sanatorium, Charlottetown, which is fully staffed and equipped, "as an Accredited Hospital in recognition of compliance with the standards approved by the Canadian Council on Hospital Accrediation for patients' care with respect to physical plant, administration, diagnostic and treatment facilities, and the supervision, review and analysis of clinicla work by an organized and competent medical staff."

B. Recommendations for improvement of present facilities

(1) The service of a full-time Public Health Nurse to meticulously follow up contacts of know active cases of tuberculosis and positive tuberculin reactors among children, many of whom benefit by the administration of tuberculostatic drugs (I.N.H.) for prophylactic purposes on an out-patient basis.

(2) The services of an additional part-time internist, specially trained in chest diseases.

(3) The services of a qualified Public Health Educator.

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3. Treatment

Complete treatment services are available in the Provincial Sanatorium [illegible], which is fully staffed and equipped [illegible] an Approved Hospital in recognition of compliance with the standards approved by the Canadian Council on Hospital Accreditation for patients' care with respect to physical plant, administration, diagnostic and treatment facilities, and the supervision, review and analysis of clinical work by an organized and competent medical staff.

B. Recommendations for improvement of present programs

(1) The service of a full-time public health nurse to medicinally follow up contacts of open active cases of tuberculosis and positive tuberculin reactors among children, many of whom benefit by the administration of tuberculostatic drugs (I.N.H.) for prophylactic purposes.

(2) The services of an additional part-time internist specially trained in chest diseases.
(3) The services of a qualified Public Health Educator.

APPENDIX D

MENTAL AND EMOTIONAL ILLNESS

Services and facilities provided by the Government of Prince Edward Island for the management of mental illnesses consist of the following:

1. Riverside and Hillsborough Hospitals with some seventy-five beds for active treatment and some two hundred and fifty beds for care of the chronically insance, the difficult geriatric problems, and some mental defectives.
2. A tax supported Child Guidance Clinic in the Charlottetown Area with a Child Psychiatrist and ancillary staff of Psychologist and Social Worker. This child guidance team also serves the Summerside area on a "travelling clinic" basis.
3. One Speech Therapist who is stationed at the Mental Health Clinic in Charlottetown.
4. One Liaison Teacher who is a member of the Mental Health Clinic staff and who provides a consultative service for teachers throughout the province for their problem children.
5. One Social Worker who devotes her full time to the Retarded, and counselling the parents of retarded children.
6. Tax supported out-patient services are now provided to adults in the Summerside area one day a week. Plans are now being laid to re-establish this type of program in

Services and facilities provided by the Government of Prince Edward Island for the management

and some two hundred and fifty beds for men on the chronically insane, the mentally [illegible] problems, and some mental deficiencies

2. A tax supported Child Guidance Clinic [illegible] and auxiliary staff of Psychologist and Social Worker the [illegible] and [illegible] office used.

3. One Speech Therapist who is [illegible] the Mental Health Clinic in Charlottetown

4. One Library Teacher who is a member of the Mental Health Clinic staff and who provides a consultative service for teaching children out the province for their particular disorders.

5. One social worker who devotes her full time to the Mentally [illegible], and counselling the parents of retarded children.

6. Tax supported out patient [illegible] provided to adults in the Summerside area one day a week. Plans are now being [illegible] to re-establish this type of [illegible]

Charlottetown, to expand it in the Summerside area, and to extend it to other centres in the Province.

7. Construction has now been started on a cottage type Hospital-School for Retarded Children. This will provide space for in-patient facilities for twenty-one cases, a Day training class for children at Imbecile level, and a "Day Care Program" for some of the older retarded and children who are not suited to the Day Training Class.

Preventive measures in this field are restricted to the role played by the following:

(1) Physicians in private practice.

(2) Adult Mental Health Clinic Services.

(3) Personnel in the Division of Child Welfare.

(4) Private Welfare Agencies.

(5) Case finding services provided by Public Health Nurses. It is recognized that this does not provide an adequate program.

The program of Rehabilitation of the Mentally Ill is only in its fledgling stage and services are as yet geared primarily to therapy. An Industrial Therapy Program has been developed to some extent at Riverside Hospital, and a program of co-operation with the Special Placement Services of the Unemployment Service Commission has recently been initiated. A Foster Home Program for Mental Patients is now being developed which can also be utilized toward this end. Adequate Social Work staff is now training, and this will

Charlottetown, to expand it in the Summerside area, and to extend it to other centres in the Province.

7. Consideration has now been directed to a Children. This will provide space for in-patient facilities for twenty-one cases, a level, and a "Day Care Program" for some of the older retarded and children who are entitled to the Day Training Class.

Preventive measures in this field are re-related to the role played by the following:

(3) Personnel in the Division of Mental Health.

(4) Private welfare agencies.

(5) Case finding services provided by Public Health Nurses. It is recognized that this does not provide an adequate program.

The program of Mental Hygiene of the Division

III is only in the fledgling stage and service is geared primarily to therapy. An Industrial Therapy Program has been developed to some extent in Riverside Hospital, and a program of co-operation with the special Placement Services of the Employment Service Commission has recently been initiated. A Foster Home Program for Mental Patients is now being developed which can also be utilized towards this an adequate Social Work staff is now training, and this

allow further progress with this program of rehabilitation.

In the following areas the services presently provided are somewhat inadequate.

1. Though satisfactory psychiatric services are available to the Charlottetown and Summerside areas, the time factor involved in transportation makes continuing out-patient treatment difficult for the other areas of the province.

2. Efforts should be directed toward making positions of professional nurses and nursing assistants more attractive so as to reduce the rapid turnover of staff and provide continuity of nursing care at mental hospitals.

3. Though every effort is being made to provide additional Social Workers through sponsored training, the Occupational Therapy and Industrial Therapy services are sadly lacking in qualified personnel.

4. In the past there has been a lack of continuity of care of the psychiatric patient referred by the practicing physician to the provincial mental health services. Every effort is being made to overcome this deficiency, through the provision of consultations and reports to practicing physicians on all patients discharged from mental hospital.

5. Preventive Mental Health procedures available to our public schools through our Guidance

allow further progress with this program of rehabilitation.

In the following areas the [illegible] are [illegible]:

1. Though satisfactory psychiatric services are available to the Chatelaine and Gouverneur areas, the time factor involved in transportation [illegible] difficult for the other areas of the province.

2. Efforts should be directed toward making positions of professional nurses and nursing assistants more attractive so as to reduce the rapid turnover of staff and provide continuity of nursing care at mental institutions.

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4. In the past there has been a lack of continuity of care of the psychotic patient referred by the practicing physician to the [illegible] effort is being made to overcome this deficiency, through the provision of [illegible] additional and reports to practicing physicians on all patients discharged from mental [illegible]

5. Preventive Mental Health programs available to our public schools through our Guidance

Consultant are minimal and there is a great need for expansion of such services.

6. At present the educational, institutional and social work services for the mentally retarded are absent or minimal. It is expected that the facilities provided by the new Hospital School will do much to improve this situation.

7. We have no facilities for in-patient treatment of severely disturbed children at present.

8. A program for the assessment and treatment of juvenile delinquents and adult criminals should be undertaken as soon as an adequate number of trained Psychiatric Social Workers are available.

9. Facilities for the care of our aged population require better co-ordination and more adequate supervision by Medical, Psychiatric and Social Work personnel.

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6. At present the educational, instructional, recreational and sheltered or training, [illegible] are absent or minimal. It is expected that the facilities provided by the new Hospital School will do much to improve [illegible]

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9. Facilities for the care of our aged [illegible] require better co-ordination and more supervision by Medical, Psychiatric and Social Work personnel.

APPENDIX E

ALCOHOLISM AND DRUG ADDICTION

Although drug addiction on Prince Edward Island presents a problem of such small prevalence that we have insufficient practical experience on which to base any opinion, the same is not at all true of Alcoholism. Here, as elsewhere, Alcoholism presents a very major problem.

Our facilities for the care and treatment of this disorder are entirely inadequate. The only service provided at present is the care offered by the family Physician, groups such as A.A. and the provision of "drying out" facilities at Riverside Hospital.

We well realize that this is of practically no avail in attempting to deal with this major medico-psychological-social-legal problem.

We would recommend:

1. That physical facilities be provided for an adequate program for the treatment of this condition, either at Riverside or elsewhere.
2. That an adequate staff of Psychiatrists, Social Workers and Psychologists, interested primarily in this problem, be provided.
3. Again, that whatever administrative arrangements be devised, the payment for personal medical services received for this disorder be arranged for on a basis identical to that for Medical Services for other illnesses.

APPENDIX V

[illegible]

Although drug addiction on Prince Edward Island presents a problem of such small prevalence that we have insufficient practical experience on which to base any opinion, the same is not at all true of Alcoholism. Here, as elsewhere, Alcoholism presents a very major problem.

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We well realize that this is [illegible] no avail in attempting to deal with [illegible]

We would recommend:

That physical facilities be provided for an adequate program for the treatment of this [illegible]

That an adequate staff of Psychiatrists, Social Workers and Psychologists, interested primarily in this problem, be provided.

[illegible] be devised, the payment for personal medical services received for this disorder is arranged for on a basis identical to that for Medical Services for other illnesses.

APPENDIX F

CANCER CONTROL

The Department of Health of the Province of Prince Edward Island has had a Division of Cancer Control since November, 1948. The services provided by this Division are as follows:

(a) Preventive

This Division provides no services, except those considered later in diagnosis, which could be considered of a preventive nature. However, the Division of Laboratories does provide a limited cytological service. X-Rays are provided as an insured service on an In or Out-Patient basis to subscribers to the Provincial Hospital Insurance Program.

(b) Diagnostic

This Division provides a Consulting Service at the request of a referring physician. Biopsy, anaesthetic, and endoscopy procedures as necessary are provided, or charges for same authorized, in collaboration with the referring physician.

TREATMENT

The Radiotherapy of malignant and also benign conditions is provided by this Division, the Director being a Certified Radiotherapist. Therapy Units and Radium are located in and maintained in the two Charlottetown Hospitals.

The Department of Health of the Province of Prince Edward Island has had a Division of Laboratories by this Division are as follows:

(a) [illegible]

This Division provides no services, except those considered later in diagnosis, which could be considered of a preventive nature. However, the Division of Laboratories does provide a limited service on an in or out-patient basis in accordance to the "Outlines of Health Insurance Program".

This Division provides a Clinical [illegible] at the request of a referring physician. Stools, sputa, etc., can sometimes procedures as necessary provided, or charges for same [illegible]

The Radiotherapy of patients are also begun according to provided by this Division. The [illegible]

Pills and Rocky are located in and maintained in the two Charlottetown Hospitals.

APPENDIX G

LABORATORY SERVICES

Existing Diagnostic Laboratory Facilities

The various components of the laboratory services are correlated by the Prince Edward Island Laboratory Council. This is an advisory body without executive authority. Its membership consists of representatives of the Boards of Trustees and of the Medical Staffs of each of the three larger hospitals and of one of the small hospitals (in rotation), together with the Deputy Minister of Health, the Director of the Division of Laboratories of the Provincial Department of Health and a Veterinarian from the Provincial Department of Agriculture.

The diagnostic services available are as follows:

(a) Small Hospitals: Each of the four small hospitals has a small laboratory staffed by a so-called "Technical Assistant". This is an individual who receives four months' training in the Division of Laboratories and who carries out the simplest laboratory tests (urinalysis and elementary haematology and chemistry). In most of the hospitals this individual also carries out basic radiographic techniques, another four months' training in this being given in one of the large general hospitals.

(b) General Hospitals: Each of the three large general hospitals has a laboratory staffed by from two to four registered technicians with appropriate clerical

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(b) General Hospitals: Each of the three large general hospitals has a laboratory staffed by from two to four registered technicians with appropriate clerical

and wash-up help. These laboratories carry out a greater range of haematological and chemical estimations, this range including most of the routine techniques. The range of tests is greatest in the Prince County Hospital, Summerside, where more experienced staff and more elaborate equipment are necessary because of the distance from the Provincial Laboratories in Charlottetown.

(c) Division of Laboratories, Provincial Department of Health, Charlottetown

This is staffed by the Director, another qualified pathologist, a non-medical bacteriologist, about fifteen qualified technicians, trainess of various types and appropriate clerical and wash-up help. The Director is part-time, being also employed by the two general hospitals in Charlottetown and by the Canadian Red Cross Society as Director of its Provincial subdepot, Blood Transfusion Service.

The work of the Division is now largely clinical. Fifty-five percent comes from the general hospitals with another twenty-five percent from the clinical divisions of the Department of Health. About ten percent is of a purely public health nature with eight percent coming from the Department of Agriculture and two percent from the Attorney-General's Department.

All the histology and bacteriology for the province is carried out in the Division. In addition, the more complex haematology and chemistry is referred from the various hospital laboratories and a complete service in all branches is offered to all doctors for

[illegible] or range of bacteriology [illegible]

is range including most of the routine techniques. The range of tests is greatest in the Prince County Hospital, Summerside, where more experienced staff and more elaborate equipment are necessary because of the distance from the Provincial Laboratories in Charlottetown.

(c) Division of Laboratories Provincial Department.

This is staffed by the Director, another qualified pathologist, a bacteriological technician, about fifteen qualified technicians, trainees of various type and appropriate clerical and washroom help. The Director is part-time being also employed by the two general hospitals in Charlottetown and is Director Red Cross Society as Director of its Provincial Laboratory.

The work of the Division in new laboratory facilities fifty-five percent come from the general hospitals with another twenty-five percent from the clinical divisions of the Department of Health. About [illegible] percent [illegible] from the Department of Agriculture and two percent from the Attorney-General's Department.

All the bacteriology and pathology for the province is carried out in the Division. In adult the more complex haematology and chemistry is referred [illegible] service in all branches is offered to all doctors in

their office practice.

A small number of highly specialized tests, for instance hormone assays, is forwarded to other laboratories, principally the Biochemistry Department, Division of Laboratories, Halifax. Use is made of reference centres such as the Canadian Tumour Registry and the Laboratory of Hygience. In various national surveys (e.g. the periodical surveys of syphilis serology conducted by the Laboratory of Hygiene) the results obtained here have been satisfactorily accurate.

The Division is an approved training school for laboratory technologists. Students (who average about six per year) receive a sixteen month course (largely practical but partly didatic) after which they write the qualifying examination of the Canadian Society of Laboratory Technologists. The instruction of these students is a constant and time consuming task for the senior staff of the Division. Students receive a bursary from the Provincial Government during training, in return for which they agree to work in approved employment for two years after conclusion of the course.

The senior staff of the Division constitutes the only source of medical and technical supervision for the work of the hospital laboratories. In an attempt to maintain quality control, specimens are referred to these laboratories at intervals and they are visited periodically by the Director or the Bacteriologist.

(d) Sanatorium: A small laboratory, staffed by one technician, is maintained by the Division of Laboratories in the Provincial Sanatorium. It carries out

their office practice.

[illegible]

for instance normone assays, is forwarded to [illegible]

[illegible]

[illegible] of Laboratories, Halifax. Use is made of reference centres such as the Canadian Tumour Registry and the Laboratory of Hygiene. In various national surveys (e.g. the periodical surveys of syphilis carried conducted by the Laboratory of Hygiene) the results obtained here have been satisfactorily numerous.

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(d) Sanatoriums: A small laboratory, staffed by one technician, is maintained by the division at sanatoriums in the provincial sanatorium. It carries [illegible]

routine testing on the patients in the sanatorium and attending the chest clinics.

(e) Blood Transfusion: With the exception of a very small amount of matching necessarily carried on in Prince County Hospital, all the blood transfusion work for the province is carried out in the laboratory maintained by the Canadian Red Cross Blood Transfusion Service. This laboratory is situated in the same building as the Division of Laboratories. It is staffed by two technicians who are responsible for complete coverage throughout the year. This is a sub-depot to the Halifax depot, blood being received from there daily or as required. Prenatal testing of maternal bloods is carried out here.

Conditions of service of Laboratory Personnel

These are established by the Provincial Government for employees of the Division of Laboratories and by the Hospital Services Commission for the employees of hospital laboratories.

Costs

The actual operating costs of the Division of Laboratories are charged to the various hospitals, departments and divisions utilizing its services on a proportional unit basis. Work carried out on specimens submitted from doctors' offices is charged, on the same basis, to funds available from the Federal Health Grants. Each hospital is responsible for the operating costs of its own laboratory.

All tests (with the exception of protein bound iodine estimations) are available without direct charge

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

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Qualifications of service of laboratory personnel

There are established by the [illegible] Government for employees of the Division of Laboratories and by the Hospital Service's Commission for the employees of hospital laboratories.

The actual operating costs of the Division of Laboratories are charged to the various hospitals, departments and divisions utilizing the services on a proportional unit basis. Work carried out on specimens submitted from doctors' offices is charged, on the same basis, to funds available from the Federal Health Grants. Each hospital is responsible for the operating costs of its own laboratory

All tests (with the exception of premarin [illegible] iodine estimations) are available without direct charge to

1. In-patients in hospitals -- (Tests carried out in hospital laboratory or Division of Laboratories).

2. Insured out-patients attending hospitals -- (Tests carried out in hospital laboratory or Division of Laboratories)

3. Patients in doctors' offices -- (Tests carried out in Division of Laboratories)

The only category of patients who pay directly for laboratory work is, therefore, the non-insured hospital out-patients.

Consideration of the above report points out certain deficiencies, the removal of which should be considered as essential to providing complete laboratory service for this province. These points are listed as follows: --

1. The laboratory facilities of Prince County Hospital should be expanded so that the laboratory there could act as a regional laboratory for the western part of the Province, the work to include simpler diagnostic bacteriology, including Public Health bacteriology.

2. That administrative machinery should be set up so that doctors outside Charlottetown could have laboratory work on patients seen in their offices carried out in the nearest hospital laboratory instead of this having to be referred to the Division of Laboratories in Charlottetown.

3. That the laboratory staff should be increased

in hospital laboratory or Division

(Tests carried out in hospital laboratory or Division of laboratories)

(Tests carried out in Division of

The only category of patients who may difficulty for laboratory work is, therefore, the non-insured

Consideration of the above report points out certain deficiencies, the removal of which should be considered as essential to providing complete laboratory service for this province. These points are listed as follows:--

1. The laboratory facilities of Prince County Hospital should be expanded so that the laboratory there could act as a regional laboratory for the western part of the province, the work to include simple

2. That administrative machinery should be set up so that persons outside Charlottetown could have laboratory work on patients seen in their offices carried out in the nearest hospital laboratory instead of having to be referred to the Division of Laboratories in Charlottetown.

by the addition of a bacteriologist or biochemist (preferably medical) to allow more supervision, especially of the hospital laboratories, and more consultative work.

4. That it would be desirable to have, in any future (and much needed) expansion of premises, the Division of Laboratories situated in closer proximity to one of the general hospitals rather than in a primarily administrative building.

5. That in the future it would be desirable to have some virological techniques carried out here rather than referring the specimens to Halifax.

6. That salaries and working conditions of laboratory personnel be made more uniform throughout the country in order to reduce the loss of professional and technical skill from the Atlantic area.

APPENDIX H

PROVISION OF DRUGS AND BIOLOGICALS

The following drugs and biologicals are available to physicians through the Department of Health for the purposes indicated --

1. GAMMA GLOBULIN

   A. Prophylaxis against:

   (1) Measles - Children under four years of age and older children otherwise ill or debilitated, exposed to measles. Also pregnant women, especially in first trimester.

   (2) German Measles -- Pregnant women, especially in first trimester, exposed to German Measles.

   (3) Infectious Hepatitis -- Contacts of clinical cases.

   (4) Poliomyelitis -- Contacts of clinical cases where thought advisable.

   B. Treatment:

   Agammaglobulinemia -- Clinical cases.

2. POLIOMYELITIS, SALK VACCINE

   For immunization of adults.

3. PENICILLEN

   Prophylaxis against Rheumatic fever.

4. FIBRINOGEN

   For treatment of post-partum bleeding due to afibrinogenemia.

5. SULFA

   (a) Contacts of meningococcal infections and

   (b) Dysentery infections to clear the carrier state

APPENDIX H

V O

The following dosage and administration [illegible]

I. GAMMA GLOBULIN

A. Prophylaxis against:

(1) Measles - Children under four years [illegible] older children otherwise [illegible] exposed to measles. Also [illegible] especially in first trimester

(2) [illegible] - [illegible] in first trimester, exposed to [illegible]

(3) Infectious Hepatitis - Members of [illegible]

(4) Poliomyelitis -- Contacts of [illegible] cases

B. Treatment:

Agammaglobulinemia - Clinical cases.

II. POLIOMYELITIS, SALK VACCINE

For immunization of [illegible]

[illegible]

Prophylaxis against Influenza Virus.

[illegible]

For treatment of post-vaccinal [illegible] [illegible] arthrinogenesis

C. SUTURE

(a) Contents of Neurological [illegible]

The Prince Edward Island Medical Association recommend that this service be extended as follows:--

1. That Insulin and Tobutamide be made available in diabetes.

2. That Liver Extract and Vitamin B_{12} be made available in pernicious anaemia.

3. That steroids be made available in Addisons disease.

4. That these and certain other drugs be made available for prolonged therapy where indicated when financial need is demonstrated.

APPENDIX I

REHABILITATION SERVICES IN PRINCE EDWARD ISLAND

The facilities available for rehabilitation in Prince Edward Island can be considered under two subheadings -- Governmental and non-Governmental.

(A) Governmental

The facilities offered by the Provincial Government are in a Rehabilitation Centre located in the Provincial Sanatorium building. In-Patient facilities are mainly for the orthopedically disabled, with priority given to cases of poliomyelitis and bone and joint tuberculosis, and to children up to the age of sixteen years. Other orthopedically disabled cases are admitted when beds are available. Included in the facilities at the Rehabilitation Centre is a large department covering all phases of physiotherapy. A Physiotherapy Unit located in the Prince County Hospital, Summerside, is also under the administration of the Rehabilitation Centre.

Physiotherapy Services have recently been extended to the Community Hospital, O'Leary, and the Western Hospital, Alberton. A part-time physiotherapist attends each hospital twice weekly, and the two units have been equipped to handle only acute cases. Chronic cases requiring more complicated physiotherapy can be referred to the Rehabilitation Centre for treatment.

The Occupational Therapy Department, under the direction of a fully qualified occupational therapist, is in the process of organization. This treatment is

The facilities available for rehabilitation in Prince Edward Island can be considered under two headings:

(A) Governmental

The facilities offered by the Provincial Government are in a Rehabilitation Centre located in the Provincial Sanatorium building. In-patients referred are mainly for the orthopaedically disabled, with priority given to cases of poliomyelitis and other joint tuberculosis, and to children up to the age of sixteen years. Other orthopaedically disabled persons are admitted when beds are available. Included in the facilities at the Rehabilitation Centre is a department covering all phases of physiotherapy. A Physiotherapy Unit located in the Prince County Hospital, Summerside, is also under the administration of the Rehabilitation Centre.

Physiotherapy Services have recently been extended to the Community Hospital, O'Leary, and the Queens County Hospital, Alberton. A physiotherapist attends each hospital twice weekly, and the two units have been equipped to handle only acute cases. Chronic cases requiring more complicated physiotherapy are referred to the Rehabilitation Centre for treatment.

The [illegible] direction of a fully qualified occupational therapist in the process of organization. This department is

available mainly to In-Patients for the time being, but after it is well underway, will be made available for patients suffering from poliomyelitis or bone and joint tuberculosis only.

The Surgical Facilities of the Rehabilitation Centre are arranged so that all orthopedic procedures are carried out in the operation room of the Provincial Sanatorium, with postoperative care being provided at the Rehabilitation Centre. A Medical Assessment Board consisting of four physicians nominated by the Provincial Medical Society is responsible for supervision over the admission, treatment and discharge of all patients at this Centre.

(B) Non-Governmental Facilities

For the past three years there have been organized physiotherapy departments in the two general hospitals in Charlottetown -- The Charlottetown Hospital and the Prince Edward Island Hospital. Both these hospitals are well equipped to handle cases of an acute nature, rather than long-standing chronic cases which are mostly handled at the Rehabilitation Centre.

Recommendation

The overall Rehabilitation program in Prince Edward Island is comparatively new as compared with those of the other provinces of Canada, but is working quite satisfactorily. The primary needs are for a Medical Social Worker and the services in Speech Therapy.

joint tuberculosis only.

The Surgical Facilities of the Rehabilitation Centre are arranged so that all orthopedic procedures are carried out in the operation room of the Provincial [illegible] the Rehabilitation Centre. A Medical Assessment Board consisting of four physicians nominated by the Provincial Medical Society is responsible for supervision over the admission, treatment and discharge of all patients at this Centre.

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Recommendation

The overall Rehabilitation program in Prince Edward Island is comparatively low as compared with that of the other provinces in Canada, but is moving quite satisfactorily. The primary needs are for a Medical Social Worker and the services in Speech Therapy

APPENDIX J

HISTORY OF THE CURRENT OPERATIONS OF THE HOSPITAL AND DIAGNOSTIC SERVICES INSURANCE PLAN

YEARS 1959 AND 1960

This is a factual analysis of the various aspects of hospitalization and hospital experience in Prince Edward Island during the years 1959 and 1960, with a prediction for the year 1961 and, where possible, a comparison with the actual experience of hospitals in the year 1958 - the last full year of operation prior to implementation of the program.

This information has been obtained from audited financial statements, budgetary approvals, annual returns of hospitals, or other reporting data available to the Commission.

The 1960 Interim Report of the Hospital Service Commission, as filed with the Legislature, details the Divisional and Advisory Committee functions of the various administrative branches of the Commission and indicates that the cost of administration of a comprehensive, government-sponsored hospital insurance plan in this Province will be in excess of $170,000 per annum, or a per capita cost of $1.70 and will represent 0.7% of the gross cost of providing hospital care to the residents of the Province.

It is noted that the Plan was responsible for over 90% of all patient days of care rendered to in-patients hospitalized in the year 1960, and only 3.3% was

This is a factual analysis of the various aspects of hospitalization and hospital experience in Prince Edward Island during the years 1959 and 1960, with a prediction for the year 1961 and three year plan in the year 1968 - the last full year of operation prior to implementation of the programme.

This information has been obtained from audited financial statements, hospitals' annual reports of hospitals, or other reporting data available to the Commission.

The 1960 Interim Report of the Hospital Services Commission, as filed with the Legislature, contains the Divisional and Advisory Committee Functions of the various administrative branches of the Commission and indicates that the cost of administration, on a comprehensive, government-sponsored complete programme, in this province will be in excess of $17.00 per annum or a per capita cost of $1.70 and will represent 0.77% of the gross cost of providing hospital care to the residents of the province.

It is noted that the plan was designed to cover over 90% of all patient days of care required in the

provided to uninsured residents. Some 396 insured residents received out-of-province hospital care at a cost of over $109,000 in the year 1960. It is estimated that the out-of-province benefits to insured residents will exceed $150,000 in the current year - 1961.

Schedule two of this brief indicates:

1. The rated bed capacity exceeds the actual bed complement of five hundred and ninety-two at December 31, 1960 and that the available beds in this Province is over seven hundred, or seven beds per one thousand population.
2. The percentage of utilization in every hospital is well below the recognized 80% for efficient operation
3. The Chronic and Rehabilitation beds are approaching a ratio of 1.5 beds per thousand population when at this date one hundred and thirty-three rated beds are available in this Province.
4. The percentage increase in utilization has not materially increased in any hospital, in spite of the added incentives inherent in any prepaid hospitalization program and the ready availability of beds in almost every hospital.

What this schedule does not clearly portray is the very wide range of fluctuation which occurs during a peak period of utilization in the months of November to April, when our three larger hospitals operate at 80-85% of beds set up, nor does it indicate the markedly reduced occupancy during the months of June to October, when these same hospitals experience a utilization rate of less than 60% occupancy.

residents received out-of-province hospital care on a cost of over $109,000 in the year 19[illegible]. It is estimated that the out-of-province benefits to insured residents will exceed $150,000 in the current year - [illegible].

Schedule two of this brief indicates:

1. The rated bed capacity exceeds the actual bed complement of five hundred and ninety-two at December 31, 1960 and that the available beds in both [illegible] is over seven hundred, or seven beds per one [illegible].

2. The percentage of utilization in every hospital is well below the recognized 85% for efficient operation.

3. The Chronic and Rehabilitation beds are approximately a ratio of 1.5 beds per thousand population. [illegible] this date one hundred and thirty-three [illegible] beds are available in this province.

4. The percentage increase in utilization has not materially increased in any hospital, in spite of the added incentives inherent in any phase hospitalization programme and the ready availability of beds in almost every hospital.

What this schedule does not clearly indicate is the very wide range of fluctuation which occurs during a peak period of utilization in the months of November to April, when our three larger hospitals operate at 80-85% of beds set up, nor does it indicate the actual reduced occupancy during the months of June to October of less than 60% occupancy.

Likewise, it does not reveal the high rate of occupancy normally experienced on the medical-surgical service of Prince County Hospital.

For the most part, residents are able to obtain admission to hospital without a waiting period and no backlog of elective admissions has been built up at any time during the past two years, with the exception of T. and A. admissions in the early summer months.

Scheduel No. 3 indicates the very marked increase in the utilization of available diagnostic and therapeutic services, ranging from a low of 10% in surgical operations and a 12% increase in diagnostic radiology for in-patients to the high increases of 90% for out-patient radiological services, 50-60% for Laboratory Units of service, and where new services were introduced in some of our hospitals in respect of Physiotherapy Treatments or Electrocardiograph Examinations the overall increase amounts to many times the previous years' experience. This is due in part to the fact that these services previously provided on a fee for service basis in physicians' offices are now provided as an insured out-patient hospital service. In presenting and analyzing Schedule 4 "Personnel and Paid Hours of Work" it should be noted that reporting data in respect of "paid hours of work" for the year 1959 may contain some degree of inaccuracy, since one or two of the hospitals reported on an "actual at work" rather than paid hours basis, however, this difference would not account for more than 3.5% fluctuation in the totals contained in this schedule.

of occupancy normally experienced on the medical-

obtain admission to hospital without a waiting period and no backlog of elective admissions has been built up at any time during the past two years, with the exception

Exceptional No. 3 indicates the very marked increase in the utilization of available diagnostic and therapeutic services, ranging from a low of 10% in surgical operations and a 125% increase in diagnostic radiology for in patients to the high increases of 200% for out-patient radiological services, 200% for Laboratory Units of services. An even more marked increase is experienced in some of our hospitals in regard to

the overall increase amounts to many times the previous year's experience. This is due in part to the fact that these services previously omitted to a lesser or service basis as physiotherapy offices are now included as an insured out-patient hospital service. In preparing the 2nd analysis Schedule 4 "Personnel and Hours of Work" it should be noted that reporting units in respect of "paid hours of work" for the year 1961-62 contain some degree of inaccuracy in the use of the formula reported as "Actual hr work" rather than paid hours data. However, such differences do not account for more than 4.5% difference in the ratios considered in this schedule.

The following observations are made in respect of this Schedule:

1. The total number of personnel increased by one hundred and thirty-nine, or some 21%, during the year 1960, and full-time employees, excluding students, increased from five hundred and twenty-five to six hundred and forty-three, an increase of one hundred and five to two hundred and fifty-two, or by forty-seven employees, and by 23%.

2. The Agnew, Peckham "Survey of Hospital Requirements, noted that the ratio of full-time employees, year 1957, was less than one hundred employees per one hundred hospitalized patients and recommended that this ratio should be increased to at least one hundred and fifty. This Schedule reveals that at December 31, 1960, approved hospitals had a staffing complement, excluding students of six hundred and forty-five employees. Based on the Adult and Child days of care, the ratio of staff to patients was one hundred and forty-seven, thereby approaching the recommended ratio and almost identical with that reported by one of the provinces where a forty rather than a forty-four hour work week prevails.

3. The same report, "Survey of Hospital Requirements" recommended that a minimum of 3.5 nursing hours per patient per day by graduate and other nursing assistants or orderlies be made available to patients Here again that objective has been reached in 1960 when approximately 700,000 hours of care were provide by such personnel for a ratio of 4.4 hours of direct

[illegible]

[illegible] and thirty-nine, or zero 0%. during the year 19[illegible] [illegible] increased from five hundred and twenty-five to [illegible] hundred and forty-three, an increase of [illegible] and five to two hundred and fifty-two, or by [illegible] seven employees, and by 2[illegible].

2. The Agnew, Peckham "Survey of Hospital Manpower [illegible], noted that the ratio of full-time employees, were 1:[illegible]7, was less than one hundred employees per one hundred hospitalized patients and recommended that this ratio should be increased to at least one hundred and fifty. This Sub-[illegible] [illegible] December 31, 1[illegible], approved [illegible] employment, excluding students of [illegible] and one forty-five employees. Based on the April and [illegible] days of care, the ratio of staff to patients was one hundred and forty-seven, thereby [illegible] the recommended ratio and almost [illegible] [illegible] required by one of the providers where a fifty [illegible]

3. The same report, "Survey of Hospital Equipment" recommended that a minimum of 3.5 nursing hours per patient per day by graduate and other nursing assistants or orderlies be made available to patients. Here again that objective has been achieved [illegible] when approximately 100,000 hours of care were provided by such personnel for a ratio of 4.4 hours of care [illegible]

care, per patient day.

4. While the numbers of Professional and Technical personnel have been increased, there are still noticeable shortages in the categories of:

(a) Dieticians

(b) Educational Instructors, and

(c) Qualified Senior Administrative and Supervisory personnel.

Schedule 5 reveals that the cost (including interest on long term debt and depreciation on buildings) of operating hospitals has increased from $1,904,474 in 1958 to an estimated $2,820,625 in 1961, or by $916,151, and from a low of $3,000 per rated bed to an estimated $4,000 per bed in 1961.

Compared to the year 1959, the average per diem cost has increased from $13.15 to an estimated average daily patient day cost of $16.90 in 1961.

Expenditures on salaries and wages amounted to $1,333,587 in the year 1960, a per diem cost of $8.28, which represents 51% of total expenditures. This percentage and average per diem cost is, in spite of the very marked increases during the years 1959 and 1960, well below the Canadian average, and an anticipated per diem salary cost of $11.00 in 1961 may bring this Provincial average into a comparable situation with other Maritime Provinces.

The monthly count of insured residents of the Province would indicate a total in the vicinity of 85,000 persons, with a slight fluctuation up or down

[illegible]re, per patient day

(2) While the numbers of professional and [illegible] personnel have been increased, there are still noticeable shortages in the categories of:

(a) [illegible]

(b) Educational Instructors, and

(c) [illegible]

[illegible]tory personnel.

Schedule 5 reveals that the cost (including interest on long term debt and depreciation or [illegible]) of operating hospitals has increased from $[illegible] in 1948 to an estimated $[illegible] in 1961 or [illegible], and from a low of $3,000 per staffed bed in an estimated $4,000 per bed in 1961.

Compared to the year 1955, the average per diem cost has increased from $13.15 to [illegible] average daily patient day cost of $19.90 in 1961.

Expenditures on medicines and wages amounted to $1,343,367 in the year 1960, a per item cost of $3.28, which represents 51% of total expenditures. This percentage and average per diem cost is, in spite of the very marked increases during the years 1959 and 1960, well below the Canadian average, and an staff [illegible] per diem salary cost of $11.00 in 1961 was [illegible]

[illegible]

The monthly count of insured residents of the Province would indicate a trend in the vicinity of 85,000 persons, with a slight fluctuation up or down

due to seasonal considerations. A survey of income source would indicate the revenue sources as follows:

Employee Groups	35%
Collector Groups	36%
Pay Direct	29%

Premium revenue per annum has been at the rate of $100,000 per month, or $1,200,000 per year with seasonal monthly variations.

Many initial administrative problems have been resolved and it is felt that the service being rendered is being improved with each new problem that arises. It is also felt that the people of this Province have become very insurance-conscious in the past two years and their main concern now is to maintain their coverage at all times.

AVAILABILITY OF HOSPITAL BEDS
UNDER THE HOSPITAL INSURANCE PLAN

Since the ratio of rated beds, on implementation of the plan, exceeded 6.0 per 1,000 population for Active treatment, and since there has been no appreciable increase in the utilization of those beds in the year 1960 and to date in 1961, the hospitals have not experienced any undue overcrowding, and in some instances have actually experienced a decrease in occupancy as the result of a slightly reduced average length of stay of patients. The same cannot be said for the availability of Chronic Care beds, our ratio has increased from seventy-nine to one hundred and thrity-three beds per one thousand of the population and for the most part Chronic Care needs have been met through admission of

[illegible]

[illegible] indicate the revenue sources as follows:

Pay direct	20%

Premium revenue per annum has been at the rate of $100,000 per month, or $1,200,000 per year with [illegible]

Many initial administrative problems have been resolved and it is felt that the service being rendered is being improved with each new problem that arises. It is also felt that the people of this Province have become very thoroughness-conscious in the past two years and their main concern now is to maintain their coverage at all times.

ADEQUACY OF HOSPITAL CARE

Since the Act of rated beds, on inception of the plan, exceeded 6.0 per 1,000 population for active treatment, and since there has been no appreciable increase in the utilization of these beds in the year 1960 and to date in 1961, the hospitals have not yet experienced any undue overcrowding, and in some instances have actually experienced a decrease in occupancy as the result of a slightly reduced average length of stay of patients. This same cannot be said for the availability of Chronic Care beds, our ratio has increased from seventy-nine to one hundred and thirty-three beds per one thousand of the population and for the past [illegible]

of this category of patient to Active Treatment wards in almost every hospital except Prince County.

The only hospital experiencing any degree of high, constant occupancy has been Prince County. A preliminary survey by an Administrative Consultant, J. E. Osborne and an Architect from the Federal Design Division of the Department of National Health and Welfare indicates a need for both modernization of services and additional beds in Prince County and the hospital is considering ways and means to alleviate the apparent shortage of beds.

Acting on recommendations contained in the Agnew, Peckham "Survey of Hospital Requirements" report, renovation, expansion and/or modernization projects have been completed at the following hospitals:

Prince Edward Island Hospital
Western Hospital
Community Hospital
Charlottetown Hospital

Two other projects at Souris and Stewart Memorial Health Centre will be completed within the next year. King's County Memorial Hospital has taken some steps to determine the extent of a renovation or addition of beds that may be desirable in that hospital area.

The utilization of Active Treatment or Chronic Care beds will, to some extent, be dependent upon the availability of custodial beds which at this date have not been fully surveyed, however the present and planned additional beds, as noted in this brief, will in our

in almost every hospital except Prince County.

The only hospital experiencing any degree of high, constant occupancy has been Prince County. A preliminary survey by an Administrative Consultant J. E. Osborne and an Architect from the Federal Design Division of the Department of National Health and Welfare indicates a need for both modernization of services and additional beds in Prince County and the province is considering ways and means to alleviate the apparent shortage of beds.

Acting on recommendations contained in the Pyrew, Peckham "Survey of Hospital Requirements" report

Two other projects at Souris and Stanley (Kensington) Health Centre will be completed within the next year. Alberta County Memorial Hospital has taken some steps to determine the extent of a renovation or addition of some kind, may be desirable in that not, [illegible]

The utilization of Active Treatment or [illegible] Care beds will, to some extent, be dependent upon the [illegible] not been fully achieved. However the problems and [illegible]

opinion, meet the foreseeable need, both as to location and distribution.

EFFECT ON QUALITY OF MEDICAL CARE UNDER THE HOSPITALIZATION PLAN

The quality of medical care rendered in our three larger hospitals has been assured for many years through their continued efforts to retain full accreditation, as adjudicated by the Joint Commission on Accreditation of Hospitals, and more recently through the appointment of a Standards Medical Sub-Committee in these hospitals. This Committee actively scrutinizes the admission of patients, makes recommendations in respect of medical necessity for care or treatment and reviews monthly or periodically, the professional services rendered to patients in hospital.

In addition to the Medical Staff functions noted above, a Medical Advisory Committee appointed by the Hospital Services Commission acts as an assessment board and if deemed necessary may act in a supervisory capacity to determine and advise the hospital medical staff or the Commission in the matter of quality of medical care rendered to insured patients

All hospitals have organized medical staffs and the governming body holds ultimate and supreme authority in the appointment of members to the medical staff, all cases admitted to hospital are reviewed by the Medical Advisor to the Commission, who may require additional information from the attending physician to

opinion, meet the foreseen [illegible]
location and distribution [illegible]

The quality of medical care rendered [illegible]
our three larger hospitals has been assured for many
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on Accreditation of Hospitals, and more recently
through the appointment of a Standards Medical Sub-
committee in these hospitals. This Committee
actively scrutinizes the admission of patients, makes
recommendations in respect of medical necessity for
care or treatment and reviews monthly or bi-monthly
in hospital.

In addition to the Medical Staff functions
noted above, a Medical Advisory Committee appointed
by the Hospital Services Commission acts as an
assessment board and if deemed necessary may act in a
supervisory capacity to determine any serious
hospital medical staff or the Commission in the matter
of quality of medical care rendered to the two psychiatric
[illegible] hospitals in organized medical staff
and the governing body holds ultimate and [illegible]
authority in the appointment of members to the medical
staff, all cases submitted to hospital are reviewed a
[illegible] to the Commission, [illegible] may result
[illegible] from the above [illegible]

justify the diagnosis, the length of stay, or medical necessity for such admission.

It is apparent from the very major increase in drug utilization since the commencement of the Plan that some degree of control, preferably through the voluntary efforts of each hospital medical staff or through the Medical Advisory Committee to the Hospital Services Commission, may be not only desirable, but economically necessary. Where an active pharmacy committee of the medical staff exists, the per diem drug cost is well below the Commission's arbitrary standard, in others it is markedly and unexplainably higher.

The Director of the Division of Laboratories acts as a part-time consultant to two of the larger hospitals and through the Laboratory Council holds some supervisory responsibility for the quality of the laboratory services rendered in hospitals, in addition all hospitals utilize the services of the Central Laboratory.

There is every reason to suggest that within the next few years two or three of our small hospitals will meet the requirements for accreditation.

EFFECT ON HOSPITAL OPERATING COSTS
UNDER THE HOSPITALIZATION PLAN

A significant factor affecting costs has, of course, been the substantial increase in the number of employees and the salary or wage increases which have occurred in the past two years. These increases were budgeted by the hospitals to meet a long felt need

[illegible]

[illegible]

[illegible] plan that some degree of control, preferably through the voluntary efforts of each hospital medical staff or through the Medical Advisory Committee to the Hospital Services Commission, may be not only desirable, but economically necessary. Where an active pharmacy committee of the medical staff exists, the per diem drug cost is well below the Commission's arbitrary standard, to which it is normally and inexplicably higher.

The Director of the Division of Laboratories [illegible] acts as a part-time consultant to two of the [illegible] respectively and through the Laboratory Division [illegible] the supervisory responsibility for the quality of laboratory services rendered in hospitals, in addition all hospitals utilize the services of the Central Laboratory.

[illegible] the past few years [illegible] of our [illegible] will meet the requirements for accreditation.

[illegible]

of course, been the unprecedented increase in [illegible] of employees and the salary or wage increases [illegible] have occurred in the past two years. There [illegible]

Insofar as funds were available, and personnel to staff essential services, as determined by the hospital concerned were to be obtained, the Commission has approved and supports this major increase in salaries and wages. A very marked increase in the quantity of care rendered to patients has been effected by this increase and hospital personnel now enjoy personnel policies, a 44 hour work week, sick leave and holiday allowances and in three hospitals Sickness or Retirement Benefits, comparable with those in other Maritime Provinces.

The provision of a wide range of diagnostic and therapeutic services on an out-patient basis increased the volume of service rendered in these departments and accounts for a substantial part of the increased cost of Supplies and Services.

The other item of increasing costs is the result of the changing pattern of therapy with the utilization of more expensive and in particular, newer types of drugs, which is causing concern to the Commission and some financial embarrassment in those hospitals where the average per diem cost of drugs, Medical and Surgical Supplies exceeds the arbitrary standard of $1.50.

The overall control of expenditures within an approved budget, as adjudicated by the Hospital Services Commission, is however the most significant factor in determining the cost of operating hospitals under a prepaid government sponsored hospitalization plan. Where a hospital establishes administrative

[illegible] as funds were available and measures to [illegible]

hospital concerned were to be obtained, the Commission has approved and supports this major increase in salaries and wages. A very marked increase in the quantity of care rendered to patients has been effected by this increase and hospital personnel now enjoy personnel policies, a 44 hour work week, sick leave and holiday allowances and to three hospitals in other Maritime Provinces.

The provision of a wide range of diagnostic and therapeutic services on an out-patient basis increased the volume of service rendered in these departments and accounts for a substantial part of the increased cost of supplies and services.

The extra item of increasing cross is the result of the changing patterns of therapy with the utilization of more expensive and in particular, newer types of drugs which is causing concern to the Commission and some financial embarrassment in those hospitals where the average per diem cost of drugs, medical and surgical supplies exceeds the provincial standard of $1.50.

The overall control of expenditures within an approved budget as adjudicated by the Hospital Services Commission, is however the most significant factor in determining the cost of operating hospitals under a provincial government sponsored hospital [illegible]

techniques on policies and maintains reasonable and up-to-date accounting or statistical records to control expenditures as budgeted, the hospital is materially and financially better able to meet the hospital care needs of its residents than in any time in its past history.

Appendix J

SCHEDULE NO. 2

1. Distribution of Hospitals approved under the Hospitalization Plan

Name of Hospital	Rated Capacity 1959	1960	1961	Adult & child Days of Care Estimated 1959	1960	1961
(a) Active Treatment						
Charlottetown Hospital	191	191	191	43,773	45,195	47,000
Prince Edward Island Hos.	188	192	192	39,622	42,064	44,000
Prince County Hospital	119	119	119	31,067	31,178	32,000
Western Hos.	22	22	46	8,777	8,078	8,400
Kings County Mem. Hos.	34	34	34	8,098	8,473	8,500
O'Leary Community Hos.	26	26	26	5,781	6,225	6,500
Souris Gen. Hospital	19	19	19	4,043	2,947	3,450
Stewart Mem. Health Centre	10	10	10	3,011	2,390	2,500
Totals	609	613	637	144,163	146,550	152,350
(b) Chronic & Rehabilitation						
Prince County Annex	49	49	49	7,322	7,254	6,000
Prince Edward Island	-	-	45	-	-	-
Western	-	-	9	-	-	700
Rehabilitation Centre	30	30	30	8,656	7,122	7,500
Totals	79	79	133	15,978	14,376	14,200

Name of Hospital	Rated Capacity 1959	1960	1961	Adult & Child Days of Care 1959	1960	1961
(a) Active						
Hospital						
Prince Edward Island Hos.	188	192	192	39,522	42,064	44,000
Prince County Hospital	119	115	119	33,067	31,140	32,000
Western Hos.	22	22	16	6,177	6,027	[illegible]
King's County Mem. Hos.	34	34	34	6,098	6,472	[illegible]
O'Leary Community Hos.	26	26	26	5,161	6,229	[illegible]
Stewart Mem. Health Centre	10	10	10	[illegible]	2,590	[illegible]
(c) Chronic & Rehabilitation						
Acadex						
Western	-	-	9	-		
Cardigan						
[illegible]	79	79	133	15,978		

2. Patient Days of Care and Percentage of Occupany - year 1960 Based on Beds Set Up at December 31, 1960

	Bed Complement		Total Days of Care in 1960		% of Occupancy	
(a) Active Treatment	A & C	N.B.	A&C	N.B.	A & C	N.B.
Charlottetown Hospital	165	34	45,195	4,282	78	33
Prince Edward Island Hos.	189	40	42,064	3,306	61	27
Prince County	108	24	31,178	4,740	69	50
Western Hos.	34	12	8,078	1,009	65	28
Kings County Mem. Hospital	36	14	8,473	1,350	67	27
O'Leary Community Hos.	26	6	6,225	563	66	28
Souris General	22	7	2,947	587	36	28
Stewart Memorial Health Cen.	12	6	2,390	325	55	18
Totals	592	143	146,550	16,162		
(b) Chronci and Rehabilitation						
Prince County Annex	27	-	7,254	-	73	-
Rehabilitation Centre	30	-	7,122	-	68	-
Totals	57		14,376			

9. Patient Days of Care and Percentage of Occupancy -

Year 1960 Based on Beds Set Up at December 31, 1960

	Bed Complement	Total Days of Care in 1960			% of Occupancy	
(a) Active Treatment	A & C	N.E.	P&G	L.B.	A & C	N.E.
Cornwallstown Hospital	165	34	45,195	4,258	78	3[illegible]
Prince Edward [illegible]	189	40	42,364	3,306	61	[illegible]
Prince County	108	24	31,178	4,740	59	5[illegible]
Western Hos.	44		[illegible]	[illegible]		
Kings County [illegible]	35	14	5,475	1,350	42	[illegible]
O'Leary Community Hos.	26	6	5,024	563	56	[illegible]
[illegible]	[illegible]	7	2,447	587	3[illegible]	
Stewart Memorial Health Cen.	12	6	2,340	275	[illegible]	
Totals	599	43	140,050	10,102		

(b) Chronic and Rehabilitation

Prince County Annex	27		
[illegible]	[illegible]		
Totals	27	14,340	

APPENDIX J

SCHEDULE NO. 3

UTILIZATION OF DEPARTMENTAL SERVICES

	1959	1960	Increase	% Increase
1. Laboratory (Units of Service)				
(a) Done in Hospital	545,077	886,824	341,747	- 63%
(b) Referred to Provincial Lab.	249,349	361,239	111,890	- 50%
2. Radiology (Diagnostic)				
No. of Films taken				
(a) In-Patients	25,743	28,823	3,080	12%
(b) Out-Patients	17,587	33,534	15,947	90%
3. Radiology (Therapy)				
No. of Treatments				
(a) In-Patients	491	257	- 243	
(b) Out-Patients	866	470	- 396	
4. Surgical Services (Procedures)				
(a) In-Patients	5,052	5,607	555	10%
(b) Out-Patients	2,663	2,877	214	8%
5. Obstetrical Deliveries	2,748	2,741	7	
6. Physiotherapy Treatments				
(a) In-Patients	1,672	9,211	7,539	450%
(b) Out-Patients	1,143	3,338	2,295	200%
7. E. C. G. Examinations	1,112	6,096		450%

APPENDIX 1

	1959	1960	Increase	% Increase
1. Laboratory (Units of Service)				
(a) Done in Hospital	545,017	885,424	341,407	- 63%
(b) Referred to	246,349	357,239	111,890	- 50%
No. of Films taken				
(a) In-patients	29,473	23,853	3,080	12%
(b) Out-patients	17,547	33,534	15,987	90%
No. of Treatments				
(a) In-patients	491	257	- 243	
(b) Out-patients	666	470	- 196	
4. Surgical Services (procedures)				
(a) In-Patients	5,052	5,607	555	10%
Delivories				
6. Physiotherapy Treatments				
(a) In-Patients	1,042	9,211	7,339	450%
(b) Out-Patients	1,143	3,387	2,245	200%
7. E. C. G. Examinations				

APPENDIX J

SCHEDULE NO. 4

1. Number of full time personnel in Hospitals as at December 31st.

By Category of Personnel	1959	1960	Increase	%Increase
1. Medical				
Radiologist	2	2	-	-
Interns	2	3	1	50%
2. Professional and Technical				
Dieticians	2	2	-	-
Laboratory Technicians	9	14	5	55%
Radiology Technicians	7	13	6	85%
Physiotherapists	2	2	-	-
Pharmacists	3	4	1	33%
Medical Records	3	7	4	133%
9. Nursing (Administration)				
Senior Administrative	9	9	-	-
Educational Instructor	8	9	1	13%
Supervisory	20	20	-	-
4. Direct Care Nursing				
Head Nurses	19	23	4	21%
General Duty Nurses	99	116	17	18%
Licensed Nursing Assistants	32	36	4	12%
Orderlies	14	16	2	14%

APPENDIX 1

Questionnaire

1. Number of full time personnel in Hospitals as at December 31st.

By Category of Personnel

	Jan.	Dec.	Increase	Decrease
1. Medical				
Radiologist	2	2	-	-
Interns	2	3	1	50%
2. Professional and Technical				
Laboratory Technicians	9	14	5	55%
Radiology Technicians	7	13	6	85%
Physiotherapists	2	2	-	-
Pharmacists	3	4	1	33%
Medical Records	3	7	4	133%
3. Administrative				
Senior Administrative	9	9	-	-
Educational	8	9	1	13%
Supervisory	20	20	-	-
4. Direct Care Nursing				
Head Nurses	19	23	4	21%
General Duty Nurses	99	116	17	18%
Licensed Nursing Assistants	32	36	4	12%
Orderlies	14	16	2	14%

Appendix J - Schedule No. 4 (continued)

Ward Aides and Clerks etc.	41	61	20	45%
5. Educational				
Student Nurses	168	174	6	4%
Nurse Asst. Trainees	4	19	15	375%
6. General Services				
Administration	42	50	8	18%
Dietary	89	94	5	4%
Laundry and Linen	26	38	12	45%
Housekeeping	55	69	14	25%
Physical Plant	32	34	2	6%
Other Personnel	9	19	10	100%
Totals	697	836	139	20%

Ward Aides and Clerks etc.	41	61	20	15%
5. Educational				
Student Nurses	168	174	6	4%
Trainees	4	19	15	375%
General Services				
Administration	42	50	8	
Dietary				
Laundry and Linen	45	57	12	
Housekeeping	55	69	14	
Physical Plant	32	34	2	
Other (Specify)	9	19	10	
	637	836	199	

APPENDIX J

SCHEDULE NO. 4 (CONT'D)

2.

Distribution of Paid Hours of Work

(a) By Category of Personnel

	1959	1960	Increase	%Increase
Graduate Nurses	354,336	430,215		21%
Student Nurses	334,663	381,819		-
Other Nursing Staff	202,427	236,679		16%
Other Personnel	713,803	804,193		12%
Total Paid Hours of Work	1,605,229	1,952,906	34,677	21%

(b) Hours of Work per patient day.

Direct Care Units	3.6	4.4
Special Services	1.3	1.6
Supplemental Services Education	.9	1.2
General Services	4.2	4.9
Total per patient day	10.1	12.1

Based on adult and child day of care - All hospitals.

APPENDIX 1

SCHEDULE NO. 4 (CONT'D)

Distribution of Paid Hours of Work

(a) By Category of Personnel

		1960	
Student Nurses	334,663	381,819	-
Other Personnel	713,803	804,193	12%
Total Paid Hours of	1,605,229	1,952,906	34,677	21%

(b) Hours of Work

Direct Care Units	3.6	4.4
Special Services	1.3	1.6
General Services	4.2	4.9
Total per patient	10.1	12.1

Based on adult and child day of care - All hospitals.

APPENDIX J

SCHEDULE NO. 5

GROSS OPERATING COSTS OF APPROVED HOSPITALS

	1958	1959	1960	1961
1. Gross Salaries and Wages	$941,684	$1,088,784	$1,333,587	$1,525,864
2. Drugs, Medical & Surgical Supplies	152,994	176,300	216,200	209,418
3. Other Supplies & Services	591,659	638,175	740,365	796,214
4. Other Expenses and Depreciation	218,173	199,416	285,083	289,129
Gross Operating Expenses	$1,904,474	$2,105,724	$2,575,235	$2,820,625

	1958	1959	1960	1961
1. Salaries				
2. Drugs, Medical & Surgical Supplies	152,994	176,300	216,200	209,418
3. Other Supplies & Services	591,659	638,175	740,365	796,214
4. Other	218,173	199,416	285,083	289,124
Gross Operating	$1,904,444	$2,105,724	$2,575,235	$2,820,027

Appendix K

Tabulation of Results Received from Questionnaire Sent to Provincial Medical Licensing Authorities.

Total Fully Registered, Active, Resident Physicians (December 31st of Each Year)

Province	1950	1951	1952	1953	1954	1955	1956	1957	1958	1959	1960	Physician Population Ratio Dec. 31, 1960
Nfld.	154	163	178	200	199	215	228	251	241	275	277	1:1682
P.E.I.	NA	NA	69	81	83	80	83	82	81	80	87	1:1207
N.S.	NA	582	609	NA	642	670	678	703	712	693	719	1:1013
N.B.	337	337	353	360	373	385	378	400	410	431	445	1:1362
Quebec	4,145	4,150	4,311	4,452	4,559	4,793	4,905	5,163	5,397	5,622.	5,863.	1:883
Ontario	5,523	5,642	5,822	6,119	6,400	6,704	7,064	7,240	7,409	7,600	7,908	1:780
Manitoba	775	780	799	833	866	906	912	947	969	1,003	1,033	1:879
Sask.	633	662	713	750	776	811	835	864	886	925	895	1:1019
Alberta	780	804	863	916	963	995	1,041	1,097	1,141	1,221	1,280	1:1023
B.C.	NA	NA	NA	1,493	1,570	1,662	1,747	1,776	1,850	1,942	2,010	1:810
Totals	-	-	-	-	16,431	17,221	17,871	18,523	19,096	19,800	20,517	1:879

New Registrants - Graduates of Canadian Schools

												Total
Nfld.	23	14	18	15	30	14	29	22	37	27	24	253
P.E.I.	2	3	3	9	1	7	1	3	5	5	5	44
N.S.	30*	31	53	50*	49	39	48	55	40	46	43	484
N.B.	14	30	25	5	21	11	13	14	18	7	23	181
Quebec	235	277	229	235	288	286	235	269	298	274	323	2,949
Ontario	297	305	297	335	304	344	343	307	221	224	266	3,243
Manitoba	59	45	47	48	51	55	45	42	34	38	37	501
Sask.	45	62	63	50	42	47	44	48	40	35	30	506
Alberta	57	49	73	61	47	45	60	48	45	62	72	619
B.C.	86	36	109	91	100	106	91	83	81	93	99	1,025
Totals	848*	902	917	899*	933	954	909	891	819	811	922	9,805

Table 7

Tabulation of Results Received from Questionnaire
Sent to Provincial Medical Licensing Authorities.

Province	1950	1951	1952	1953	1954	1955	1956	1957	1958	1959	1960	Population
[illegible]	154	169	178	200	199	215	226	251	241	275	217	1:1682
[illegible]	NA	NA	69	71	67	80	83	82	81	80	87	1:1207
[illegible]	[illegible]	502	609	NA	612	670	678	703	712	693	719	1:1013
[illegible]	297	327	372	360	373	[illegible]	396	400	410	431	445	1:1262
[illegible]	4,145	4,150	4,311	4,429	4,559	4,793	4,905	5,163	5,297	5,622.	5,869.	1:683
Ontario	5,523	5,642	5,822	6,112	6,400	6,704	7,061	7,240	7,409	7,600	7,908	1:740
[illegible]	775	780	799	823	866	906	912	947	969	1,002	1,043	1:679
[illegible]	633	662	713	750	776	811	845	864	886	925	895	1:1019
[illegible]												
[illegible]	NA	NA	NA	1,293	1,372	1,462	1,527	1,770	1,820	1,912	2,140	1:610
[illegible]	–	–	–	–	16,221	17,221	17,721	18,242	19,050	19,600	20,517	1:879

New Brunswick - Distribution of Licensing Council

[illegible]	23	14	18	15	20	14	19	22	27	27	22	25
[illegible]	2	3	3	2	1	7	1	5	5	5	5	14
[illegible]	20*	31	53	50*	49	27	40	59	40	46	43	40
[illegible]												
[illegible]	245	277	229	239	285	306	435	580	290	275	243	2,046
[illegible]	297	305	297	255	304	344	343	397	221	224	205	3,242
[illegible]												
[illegible]	45	62	63	50	42	47	44	46	40	35	20	506
[illegible]	27	49	73	61	47	47	60	48	45	62	72	619
[illegible]	86	36	109	91	100	100	91	72	81	93	99	1,025
[illegible]	346*	902	917	895*	922	954	909	871	819	811	822	9,005

Appendix K - Page 2

New Registrants - Graduates of Foreign Schools

Province	1950	1951	1952	1953	1954	1955	1956	1957	1958	1959	1960	Total
Nfld.	15	29	50	61	94	49	77	53	74	74	83	659
P.E.I.	2	2	1	1	0	0	0	1	2	3	1	13
N.S.	16*	16	18	17*	17	23	34	40	32	42	64	319
N.B.	3	3	1	1	4	5	5	1	3	4	7	37
Quebec	1	0	0	5	13	17	19	51	45	38	35	224
Ontario	52	64	84	125	160	158	179	198	203	192	135	1,550
Manitoba	25	27	37	38	48	42	49	54	49	66	50	485
Sask.	33	44	43	43	41	48	49	69	54	62	50	536
Alberta	34	52	61	59	59	57	50	72	51	57	51	603
B.C.	15	24	44	43	52	48	34	43	44	48	45	440
Totals	196*	261	339	393*	488	447	496	582	557	586	521	4,866

NA - not available. *Estimated.

Appendix 1 - Page 2

Province	1951	1952	1953	1954	1955	1956	1957	1958	1959	1960	Total
Nfld.	17	29	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	1	1	0	0	1	2	3	1	13
N.S.	16*	16	13	17*	17	22	34	40	22	42	64	319
N.B.	3	3	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Quebec	1	0	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Ontario	52	64	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Manitoba	25	27	37	38	40	42	47	54	49	66	50	465
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Alberta	34	52	61	59	59	57	50	72	51	77	51	603
N.W.T.	15	[illegible]	[illegible]	[illegible]	32	46	34	43	44	48	45	410
Totals	[illegible]6*	26	130	132*	188	227	196	252	277	306	272	1,896

NA - not available.

Estimated Physician - Population Ratios by Provinces
December 31st, 1950, 1952, 1954, 1956, 1958 and 1960

Prov.	1950 Number of Physns.	1950 Physician Population Ratio	1952 Number of Physns.	1952 Physician Population Ratio	1954 Number of Physns.	1954 Physician Population Ratio	1956 Number of Physns.	1956 Physician Population Ratio	1958 Number of Physns.	1958 Physician Population Ratio	1960 Number of Physns.	1960 Physician Population Ratio
Nfld.	154	1:2310	178	1:2130	199	1:2020	228	1:1850	241	1:1840	277	1:1682
P.E.I.	70*	1:1390	69	1:1460	83	1:1220	83	1:1190	81	1:1250	87	1:1207
N.S.	546*	1:1130	609	1:1080	642	1:1060	678	1:1030	712	1:1000	719	1:1019
N.B.	337	1:1530	353	1:1500	373	1:1460	378	1:1480	410	1:1420	445	1:1362
Quebec	4,145	1:970	4,311	1:980	4,559	1:980	4,905	1:960	5,397	1:920	5,863	1:883
Ontario	5,523	1:830	5,822	1:840	6,400	1:820	7,064	1:790	7,409	1:800	7,908	1:780
Manitoba	775	1:1000	799	1:1010	866	1:960	912	1:940	969	1:910	1,033	1:879
Sask.	633	1:1310	713	1:1200	776	1:1130	835	1:1050	886	1:1010	895	1:1019
Alberta	780	1:1190	863	1:1150	963	1:1120	1,041	1:1100	1,141	1:1070	1,260	1:1023
B.C.	1,280*	1:900	1,418	1:870	1,570	1:840	1,747	1:830	1,850	1:840	2,010	1:810
Canada (excl. Yukon & N.W.T.)	14,262*	1:975	15,135*	1:960	16,431	1:955	17,871	1:928	19,096	1:905	20,517	1:879

*Estimated.

Sources: Physicians: C.M.A. Survey of Provincial Licensing Authorities.
Population (not shown) Estimated for December 31, from D.B.S. data

THE CHAIRMAN: Dr. Coady, do you wish to amplify or give any explanation in connection with your summary or any of your recommendations?

DR. COADY: Well, it wasn't my intention to do so, sir. Rather we had hoped that questions might be stimulated from any remarks which are contained therein and that these questions might originate from your table.

THE CHAIRMAN: Well, there will be questions, I am sure, but you should feel free to make any comments or explanations that you think are relevant as questions are put.

MR. HALL: Dr. Coady, in paragraph 3 of your summary you recommend that studies be initiated into ways and means to facilitate the provision of health services in certain rural areas. Could you tell the Commission whether you have given any consideration as to what the ways and means should be or might suggest what they could be?

DR. COADY: Yes. In the body of our brief I believe we have made a recommendation in this regard, paragraph 21, on page 6. Do you wish me to read that paragraph, sir?

MR. HALL: No, it is in the brief.

THE CHAIRMAN: If you wish to make a commentary on it, that is what we want.

DR. COADY: We had hoped that studies might be initiated which would arrive at means whereby the burden might be lightened on some of these persons whom we regard as overburdened. By that we mean that perhaps

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MR. HALL: No, it is in the brief.

THE CHAIRMAN: If you wish to make a commentary on it, that is what we want.

DR. COADY: We had hoped that studies might be initiated which would explore at means whereby the burden might be lightened on some of these persons who are inclined to [illegible]. If that we some that persons

studies might lead to a mechanism whereby greater utilization of paramedical personnel might be --

THE CHAIRMAN: We wish you to spell that out, if you would. You are here, you know the province. How would you have a greater utilization of paramedical personnel?

DR. COADY: Well, we believe, for example, that some of our rural physicians particularly are not utilizing some of the nursing facilities in the province in their offices and in the home. We believe they perhaps are doing too much themselves. We believe perhaps greater utilization could be made of modern transportation if assistance perhaps could be made available.

THE CHAIRMAN: Transportation of the doctor to the patient and of the patient to the doctor?

DR. COADY: Yes, both. Perhaps helicopters, snowmobiles when travelling conditions are difficult.

THE CHAIRMAN: Perhaps that is more particular to this province than to some other provinces?

DR. COADY: Yes, I think that is right, sir. We would hope that perhaps modern means of communications might assist the physicians here, such as walkie-talkie.

THE CHAIRMAN: Two-way radio.

DR. COADY: Two-way radios. And we had also entertained some thoughts that perhaps it might be necessary in some areas for some form of subsidization of the physician from some source to attract physicians to areas which are particularly

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depressed or where their financial remuneration would not sustain them.

THE CHAIRMAN: You see, Dr. Coady, there is a complete record being made of everything that is being said here today. That will be transcribed. It will naturally come to members of the Commission, to anyone who wishes it. But it also goes to our research staff and to those who are engaged in the studies of these ideas. The more concrete they are, they will be ideas which will be explored and tested by our research people to see just how they would fit into any program.

DR. COADY: Well, our recommendation is essentially that studies be made into these possibilities, and since these studies have not been initiated we are not prepared to make any recommendation.

THE CHAIRMAN: Well, we have initiated them. We want to know, we want to have ideas for the people we have put to study them to consider. One of the functions of the Commission is to initiate studies, and we have done that, and we would like you to tell us specifically the things we should study; not just study, but study what, in particular relationship to the province of Prince Edward Island.

DR. COADY: Well, I think I have said all I could.

DR. MacMILLAN: Mr. Chairman, perhaps I could tell you some of the things that have already been done. For example, with the cooperation of the Department of Health we have made available to all country

[illegible] would not sustain them.

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practitioners diagnostic facilities for laboratory and x-ray facilities. This has been a definite step in the welfare of the doctor in the area. This is now available. Some communities have already provided housing and office facilities to entice the doctor to come into this area where he pays a very nominal rent, and this is to entice the young man who is not financially stabilized to come, and, at some small cost to himself, go to these communities. Some of these operations have been highly successful and they have attracted medical men. The third thing is that diagnostic clinics, particularly in cancer and mental health, have been set up in different parts of the island as well as diagnostic clinics of tuberculosis. This enables the doctor to make use of these facilities when he comes into the area. These are things we feel should be explored further.

COMMISSIONER VAN WART: Doctor, turning to paragraph 79, under the "b", you state that as a basic plan certain things should be excluded, and then you state "but left for detailed study and to be made available at a later date if deemed necessary." Now, do I understand from that that you will make a study in the application of optometrists, transportation, mileage, and so on, how they should be covered in their extended plan, benefit?

DR. COADY: I don't believe such studies have been initiated yet.

COMMISSIONER VAN WART: Is it your intention to make such studies?

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DR. GOAMY: I don't believe such studies have been initiated yet.

COMMISSIONER VAN WART: Is it your intention to make such studies?

DR. MacMILLAN: If I may answer that in regards to prepayment. The reason this paragraph is in is simply that we do not feel we have the information as to what such services would cost at the present time. So that if there was a thought of initiating a program, those things on which we didn't have information should not hold up the implementation of a program. Furthermore, things like transportation and mileage might very well be handled in some other area of cost rather than in the actual prepayment of service which would be tied into it, because we have already mentioned the question of transportation being provided one way or the other, much after the fashion of school buses, this being done by a department not being concerned with health.

MR. HALL: Dr. Coady, paragraph 6 of the summary refers to a shortage of acute care beds and chronic care beds. In relation to that paragraph, can you tell the Commission whether or not you have given any study to the development of home care and visiting services as a method of alleviating the shortage referred to in paragraph 6 of the summary?

DR. COADY: I would ask Dr. Gordon Lea to answer that question.

DR. LEA: The question of carrying on further studies for custodial care, that is underway now. I believe the Department of Health -- perhaps Dr. MacNeill would care to mention it -- has already established a committee to look in it. During the past year the Hospital Services Commission have been interested in

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this and have advised that studies should be undertaken. But as far as this Association is concerned, we have not taken that up; that is part of the overall study of the Department. Perhaps Dr. MacNeill would be in a better position to answer that.

DR. MacNEILL: I might say that we are studying the custodial care of chronic care. In Summerside we have in our chronic care institution sufficient beds, but the institution is quite old, it is perhaps no longer suitable for care of hospital patients, and the hospital in Summerside is studying the problem in Summerside. As far as the custodial care beds are concerned, we feel that there is a need for custodial care beds in Prince County and King's County, and we are studying at the present time the provision for more custodial care beds in King's County. Today all of the custodial beds are in the city of Charlottetown.

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Most places feel that custodial care patients, which is not really perhaps a health problem, that they are more suited, and they are happier closer to their home, and we feel if this could be brought about it would make a better institution to take care of that type of patient. We are not doing a great deal of studying of any home care. We do provide for post-maternity care by our public health nurses. We have not in this province the Victorian Order of Nurses, which in most of the other provinces of Canada do provide home care services, but our public health nurses are doing a great deal in providing the needed home care services in many aspects of medical care.

THE CHAIRMAN: Thank you, doctor.

MR. HALL: Dr. Coady, in paragraph 10 of your summary, sub-paragraph (b) can you make any suggestion to the Commission as to what formula would be used to decide who would require government assistance, either in full or in part?

DR. MacMILLAN: Mr. Chairman, and members of the Commission, in Prince Edward Island we have certain definite findings at the present time which would answer this question. For example, we have a program now set up for hospital insurance on a premium basis. The Department of Welfare has established their own mechanisms to determine whose premiums may be payed for by the government. At the moment our intention is that this same formula would be used. Now, between that and those who ideally are self supporting, the area would have to be

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investigated further, and our thoughts are that a special assessment board would accept applications of individuals for assistance on a formula to be arranged suitable to government, the profession, and other people, probably an independent group.

THE CHAIRMAN: You have a fee under the hospital program?

DR. MacMILLAN: Yes.

THE CHAIRMAN: What is that fee for individuals of a family?

DR. MacMILLAN: $2.00 per individual per month.

DR. HALL: In paragraph 11, Dr. Coady, of the summary, and also in paragraph 85 on page 24, reference is made to a total cost of $2 million. Can you tell the Commission the method that was used to compute that cost?

DR. COADY: Once again, Mr. Chairman, I have to call on Dr. Joe MacMillan for this information.

DR. MacMILLAN: Mr. Chairman, this figure of course is a calculated guess. There are no basic figures available which will tell you how much it will cost per capita to give complete services to any group of the population. The figures are obtained from average figures of the cost per person in prepayment plans, figures taken out of the six provinces which have public assistance programs, and figures published by various authorities, corrected downward slightly, I would say about 20 per cent, for those services which we now have available, including diagnostic facilities for laboratory and radiology,

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which are now covered free of charge. That is out-patient. We have no private physicians doing lab or x-ray in Prince Edward Island at the present time. This figure, therefore is a calculated guess as to what it would cost.

THE CHAIRMAN: Can you give me the figure, percentage-wise, of the population?

DR. MacMILLAN: Excuse me, that is not in the question sir.

THE CHAIRMAN: At the 400,000 that you mentioned?

DR. MacMILLAN: This figure of twenty per cent is based on a calculation which we have accepted, and which the Hospital Commission has established, that approximately 10 per cent of the people cannot pay hospital insurance premiums. If they cannot pay, that if you double this premium we would have to calculate that perhaps another 5 per cent would then be caught in, and the other 5 per cent is based on our estimate of those who would be partially unable to pay.

COMMISSIONER VAN WART: Might I ask, Dr. MacMillan, what is the average family in Prince Edward Island, would you say six, or just on the average, or four?

DR. MacMILLAN: Mr. Chairman, Dr. Van Wart flatters us here in Prince Edward Island --

COMMISSIONER VAN WART: Including the father and mother?

DR. MacMILLAN: No, I think in the Canadian average we are about fifth in Canada. The average

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number of persons per family here I think is something between three and four. This is not the same figure as the average number of participants per contract in any scheme, because that takes in most of the individuals, and our problem here is that we have a dearth of young people in the unmarried section, under 25, because these are the people who go elsewhere in proportionately large numbers, looking for employment.

COMMISSIONER VAN WART: Taking your answer, the average family of four, and you say $20.00 per capita. That would be $80.00 per family, is that a realistic figure in this province for a plan such as this?

DR. MacMILLAN: Mr. Chairman, this does not follow that because the per capita cost is $20.00 the family rate would be $80.00. I do not like to go into the details of how it worked out, because single rates are loaded somewhat, and there are other variables.

COMMISSIONER VAN WART: On the basis of $20.00 per capita, do you feel that a realistic figure could be obtained?

DR. MacMILLAN: This is approximately the cost of our present hospital plan, $20.00 per capita. The total expenditures you see in the budget at the back, in the appendix, and we have a feeling, and from well calculated guesses, that our medical care program would cost approximately the same. We are subject to correction, because we are not basing these figures on fact, but on estimates and conjectures, and a program which has not been defined.

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THE CHAIRMAN: Dr. MacMillan, I just wanted to draw to your attention that certain figures that we have been given show that the population of this province, that the percentage of distribution is about 44 per cent under age 20?

DR. MacMILLAN: Yes, 20 and 30.

THE CHAIRMAN: No, under 20, and from 20 to 60 is 41 per cent, and over 60 you have approximately 14 per cent with a rather small old age pension class of 7 per cent.

DR. MacMILLAN: There is one estimate there that may be out a little bit. When you take the people from zero to 20, if you take those from zero to 16 and then from 16 and break it down that way, I think you will find that the zero to 16 might not be up to the national average. I think that the percentage, for example, in cities like Toronto, would be considerably higher in the 16 to 20 class. I am not sure though.

MR. HALL: Dr. MacMillan, does the figure of $20.00 that you quote is that projected to cover the recommended extended coverage which you put forward in your submission?

DR. MacMILLAN: It is intended to cover in a general way administrative costs, the basic medical services, and extended health benefits.

COMMISSIONER McCUTCHEON: What do you mean by extended health benefits?

DR. MacMILLAN: That is benefits which are ordered by a doctor, but are not administered by him, such as drugs, and in certain cases the services of a

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COMMISSIONER McCUTCHEON: What do you mean by extended health benefits?

DR. MacMILLAN: That is benefits which are [illegible] as drugs, and in certain cases the services of a

physiotherapist, and so forth.

COMMISSIONER McCUTCHEON: Does it include nursing services?

DR. MacMILLAN: They would have to be calculated differently, as far as hospitals are concerned they are handled under the Hospital Commission.

COMMISSIONER McCUTCHEON: Does your service include nursing services outside the hospital?

DR. MacMILLAN: No.

COMMISSIONER STRACHAN: Would they include dental?

DR. MacMILLAN: No.

MR. HALL: The submission on page 7, paragraph 23, contains the statement: "At the present time 20 per cent of the population of this province is covered by prepaid medical service sponsored by the profession."

DR. MacMILLAN: This is high.

MR. HALL: In your proposal, as contained in paragraph 85, you state that: "That portion of the population for whom the entire cost would be paid constitutes about 10 per cent." And that: "The additional 20 per cent would be able to meet 50 per cent, or a portion of the premium". That would leave approximately 50 per cent of the population not covered. Is that amount covered now by any other means, commercial carriers?

DR. MacMILLAN: No, they are by and large not covered, and perhaps the main reason is that they

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MR. HALL: In your proposal, as contained in paragraph 85, you state that: "That portion of the population for whom the entire cost would be paid constitutes about 10 per cent." And that: "The additional 20 per cent would be able to meet 50 per cent, or a portion of the premium". That would leave approximately 50 per cent of the population not covered. Is that amount covered now by any other means, commercial carriers?

DR. MacMILLAN: No, they are by and large not covered, and perhaps the main reason is that they

are nearly all self-employed. They are farmers and fishermen. In this province we have no large employing groups. There are a few people covered with cooperative groups and things of that nature.

MR. HALL: Would all that 50 per cent be able to meet the cost of the medical care?

DR. MacMILLAN: The only figure we have is of the Hospital Commission, and they say that 90 per cent are paying the hospital premiums. These are done in various ways, through cooperative groups and agricultural and fishing groups, who make the payments through deductions. We do not guarantee that this could be extended in equal amount, but we got this figure from the Hospital Insurance Commission.

MR. HALL: Dr. MacMillan, have you any information as to what percentage, if any, of the population of this province at the present time carries coverage with commercial carriers of insurance?

DR. MacMILLAN: This information is not accurately available to us, because the insurance industry publishes the Atlantic region, and do not break it down by provinces, but in private conversation with these people we get the impression that there are probably not more than 10 per cent, and most of these are employees of national companies with branches here, who are covered from head offices.

THE CHAIRMAN: I think you might say that your figure is relatively the same that we were given for 1959, of 11.1 per cent, and almost the same figure that the non-profit Maritime Hospital Service --

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THE CHAIRMAN: I think you might say that your figure is relatively the same that we were given for 1959, of 11.1 per cent, and almost the same figure that the non-profit Maritime Hospital Service --

DR. MacMILLAN: That was 11.3 per cent.

MR. HALL: Do you know whether those are mostly indemnity type contracts?

DR. MacMILLAN: The only service type of contracts in Prince Edward Island at the present time are a few national ones like the Canadian National Railways, which is a nationally negotiated contract, the employees of some of the motor industries, of whom we do not have very many. A few local ones, and basically only a small percentage of them are on a full service program. The service program in this area is being evolved and extended at the present time, and the indemnity are being converted to service.

MR. HALL: On page 13, paragraph 42, towards the end of the paragraph, the statement is made:

> "We deplore the factors which have resulted in a very rapid turnover in our psychiatric staff in recent years".

Could you indicate to the Commission what those factors are, the nature of those factors?

DR. COADY: Mr. Chairman, I believe in fairness that I should ask Dr. MacNeill to answer that question. It is with regard to paragraph 42. The query was made regarding the last sentence of paragraph 42, which says:

> "We deplore the factors which have resulted in a very rapid turnover in our psychiatric staff in recent years and have left us with

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MR. HALL: On page 15, paragraph 42, towards the end of the paragraph, the statement is made:

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> "We deplore the factors which have resulted in a very rapid turnover in our psychiatric staff in recent years and have left us with

definite deficiencies in this field. We believe some improvements have been made. We recommend that these factors - administrative or financial - be corrected."

DR. MacNEILL: I might say that I have been Minister of Health only for two years, and I have a lot to learn. In the preparation of this brief, we allowed the different divisional directors full scope in their presentation, and we allowed them to say pretty much as they wanted, from the different divisions, in the brief. We did it because we wanted them to have a free scope. We thought if we censored them we would be ineffective. Of course, two years ago we had quite an upset in our mental hospitals in Prince Edward Island. Because of this upset one psychiatrist resigned, two had resigned in the three years previous to that, and one resigned partially, and two psychologists threatened to resign. They made the recommendations to us, and we put a lot of these recommendations into effect. One recommendation was that a board of governors be appointed at the Riverside Hospital. We put this into effect, and we find that it is operating quite nicely. Many of their other recommendations have also been put into effect. One was that it was quite a severe over-crowding in our institution. By juggling patients, and using wards that were not being used, we have now conquered our over-crowding, according to the dominion statistics.

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We have 50 square feet of bed space for each patient in the custodial, which is on the average. We have also many rooms with T.V. and recreational rooms. We feel that the over-crowding is, according to the statistics today, comparable. We know that in the next few years they will be demanding more room for patients and we will, I hope, be able to provide them. In our active treatment centre at Riverside we have over 80 square foot of floor space per patient, and this is over and above the requirements of the dominion statistics. This is not quite as high as the American people would like. We have not reached the standards that the American Psychiatrist Associations had recommended. We hope in the future that that also will be done. I think a lot of the rapid turn-over has been conquered. Our salaries for the psychiatrists have gone up. We have a position open as director of the psychiatric provincial health program in Prince Edward Island. To date we have not a director. We have an assistant director. The salary for our director, if we could get one, and we are certainly trying to get one, is in the $13,500.00 to $14,500.00 range, and this compares quite favourably with the other provinces of Canada. It is not quite as high, of course, as some of the larger provinces. In the salary for psychiatrists, we feel they are getting very close to the scale in other provinces. They are not quite as high, but they are coming up. We feel that some improvements have been made. We have made in the last few months a very excellent survey

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by the Mental Health Association of Prince Edward Island. They made many recommendations, and we have carried a number of them into effect.

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THE CHAIRMAN: May we be provided with a copy of that?

DR. MacNEILL: Certainly, we will provide that tomorrow morning, and we hope in the next year we are to implement many of the recommendations of the Society, but this is an association which was only formed about two years ago.

DR. BECK: Mr. Chairman and members of the Commission, I can speak perhaps on this question as one of the lower echelon. It seems to me the problem resolves itself down to two main considerations.

One is the problem of administration. This was the major and, in my opinion, the only problem which caused the upset which Dr. MacNeill referred to, and I think this has likely happened very largely necessarily by the institution of the Board of Trustees over the mental health services. The Board of Trustees, it is hoped, will provide that necessary buffer between the professional staff and the various departmental and governmental agencies.

The second thing which I think is of pertinence in the turnover of psychiatric staff within the mental health services is the very broad problem of the role of the professional in a bureaucratic organization. This is a subject which we could talk on for a very long time, but in this type of organization I think it is valid to say that professional efficiency and acumen become a secondary factor to administrative and bureaucratic abilities, that the prestige tends to become associated and attached to the administrative

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The second thing which I think is of pertinence in the turnover of psychiatric staff within the mental health services is the very broad problem of the role of the professional in a bureaucratic organization. This is a subject which we could talk on for a very long time, but in this type of organization I think it is valid to say that professional efficiency and acumen become a secondary factor to administrative and bureaucratic abilities, that the prestige tends to become associated and attached to the administrative

ability rather than the professional medical ability. I think this is another very pertinent part of the problem referred to in this submission.

COMMISSIONER BALTZAN: Gentlemen, I want to express my very great personal delight with the classical presentation of the brief as it was written. Please permit me, Mr. Chairman, and I am especially pleased with the emphasis upon the philosphy of medicine, and it is refreshing to be reminded that this is a learned profession. Now, it faces new problems, from your presentations, and others we have had up until today, and largely the matter of business. Secondly, the matter of public relations and that, I presume, is an extension in a wholesale fashion of the patient-physician relationship which has been so dear to the profession. It is these things, the business and public relationships that form the subject matter largely of the business before you and before this Commission. I don't want to spoil anything that I have said by having to get some explanation on one or two things, gentlemen. I have here a reference to page i, paragraph 5 in your original summary. The question is: when you refer to mental health in a broad sense, do you then include what I would describe as the three broad divisions of the consideration of mental health. Three broad divisions: first, I think it is taken for granted, and perhaps you mean that the institutional and custodial care for the irreparably brain diseased and congenitly defective; these are perhaps permanently institutional care cases. I am

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I think this is another very pertinent part of the problem referred to in this submission.

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pleased to see you advise again the old term of the so-called insane, which term is not used today, but you include here, of course, this custodial care for this one group -- right or otherwise?

DR. COADY: Yes, they are included.

COMMISSIONER BALTZAN: As part of the hospitalization scheme?

DR. COADY: As part of the mental hospital service, yes.

COMMISSIONER McCUTCHEON: Not as part of the Hospital Insurance Services generally?

DR. COADY: No.

DR. BECK: I think the intention in the next sentence to that -- "We suggest too that our patients in mental hospital should not be excluded from the benefits of the hospital insurance plan" answers your question as "yes".

COMMISSIONER McCUTCHEON: That is right.

DR. BECK: They are now excluded, but we feel they should not be.

COMMISSIONER BALTZAN: Thank you. Also under the same heading dealing with the mental health, do you include the temporarily disturbed, the borderline remedial, established by current events and therapy, those who require psychotherapy and who are not permanently or long time in hospital patients?

DR. COADY: The majority of those are included, Mr. Chairman. A small proportion are treated on a private basis -- by private psychiatrists in our general hospitals, but those are the ones that are

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COMMISSIONER BAUTZAN: As part of the hospitalization scheme?

DR. COADY: As part of the mental hospital [illegible]

COMMISSIONER MOUTOHEHON: Not as part of [illegible]

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under the same heading dealing with the mental health, do you include the temporarily disturbed, the borderline remedial, established by current events and therapy, those who require psychotherapy and who are not permanently or long time in hospital patients?

DR. COADY: The majority of those are included, Mr. Chairman. A small proportion are treated on a private basis -- by private psychiatrists in our general hospitals, but those are the cases that are

less severely disturbed.

COMMISSIONER BALTZAN: What, may I ask, do you do, or how are these other people who do not require the hospital treatment, who require visits to a psychiatrist or trained personnel, or even the man in general practice who has good knowledge of human understanding -- are they covered, or do you want them covered?

DR. COADY: Yes, we wish to have those covered also.

COMMISSIONER BALTZAN: Then, in the broad aspects of mental health do you include whatever covers are designed for the prevention of these various disturbances which has to do with counselling, public education and all the other things -- you want that also considered in the question of mental health?

DR. COADY: Yes.

COMMISSIONER BALTZAN : Thank you very much.

DR. BECK: I am trying to undercut the philosphy underneath the series of questions. It appears to me that the feeling of the Medical Association as a whole is that psychiatric services wherever they are needed, whenever they are needed, should be provided on essentially the same pattern as services provided for other types of illness. If this is an acute psychiotic disorder which requires an admission to hospital, then this hospitalization should be covered under the hospital insurance system, the same as any other type of illness. If it is a milder type of psychoneurosis which requires psycho-

less severely disturbed.

COMMISSIONER BAILZEAN: What, may I ask, do you do, or how are these other people who do not require the hospital treatment, who require visits to a psychiatrist or trained personnel, or even the man in general practice who has good knowledge of human understanding -- are they covered, or do you want them covered?

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DR. COADY: Yes.

COMMISSIONER BAILZEAN . Thank you very much.

DR. HEUK: I am trying to understand the philosophy underneath the series of questions. It appears to me that the feeling of the Medical Association as a whole is that psychiatric services wherever they are needed, whenever they are needed, should be provided on essentially the same pattern as services provided for other types of illness. If this is an acute psychiatric disorder which requires an admission to hospital, then this hospitalization should be covered under the hospital insurance system, the same as any other type of illness. If it is a milder type of psychoneurosis which requires psycho-

therapy by a psychiatrist, then this psycotherapeutic service should also be included under any type of comprehensive medical coverage on the same basis as the coverage provided for other types of illness. Should this be a chronic long care patient, then this ill person should have the benefits of the same type of service as provided for other types of chronically disabling conditions.

COMMISSIONER BALTZAN : Thank you. My reason for raising these questions is probably easily answerable here, but we know in other provinces with longer experience, and having a longer time in hospital schemes provided by government, that only those deemed unfit, physically particularly, and require hospitalization, obtain hospitalization from their schemes providing them with hospitalization, and they do not cover out patients. That is why I want to make it clear.

DR. BECK: I think perhaps I should raise one point which is permanent here, which does not apply usually in other parts of Canada, and that is at the present time our patients in the mental hospital pay a daily rate for their hospital care. This is not usually applicable in the other provinces, but it is applicable here.

THE CHAIRMAN: What is that daily rate?

DR. BECK: $6.00 a day in our active treatment centre, and $3.00 a day in the chronic ward.

COMMISSION BALTZAN: Gentlemen, I see you

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COMMISSION BALTZAN: Gentlemen, I see you

include the question of alcoholism, the treatment of alcoholism under the heading of mental disturbances, and I want, if you could please tell me, especially the clinitions rather than others directly connected with the management of such cases, is alcoholism properly classed under the particular heading of mental treatment, or rather does it come under other aspects -- the sociological and social welfare thing?

DR. MALONEY: Mr. Chairman, alcoholism is a problem that presents many facets. It is not a simple problem; it is a very complex one, and it is a medical facet. It is the acute psychotic individual in the D.T.'s who is running around beating up the children, etc. and must get acute treatment immediately. This is No. 1. That is the medical problem. Secondly, there is the straightforwardly medical problem of the chronic alcoholic who develops a cirrhotic liver and has to have his belly capped every week. This is the second type. Thirdly, there are the group in between who fall into what we call -- we call it medicine because we believe the definition of disease is anything which causes disease or unease, and nothing causes more unease in the whole of Canada, probably, than the problem of alcoholism, and we think it is time somebody took a responsible position. There are many other facets: there is a spiritual facet in this, there is a sociological one and an economic one, and somebody must take a lead, and I think it is about time

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we did.

THE CHAIRMAN: "We"?

DR. MALONEY: The medical people.

DR. MacNEILL: I just wanted to mention the problem of alcoholism -- and Dr. Maloney certainly has mentioned it very well: we have our problems here, perhaps more so than some of the other provinces of Canada with the alcoholic. The psychiatrists at Riverside are studying the problem. We were wondering how the other provinces are doing and what they are doing in the problem of the alcoholic patient. We felt perhaps the acute alcoholic should be treated at general hospitals, and this has never been done on Prince Edward Island; it would be a change. So, we wrote to the other provinces of Canada, and we didn't get replies from all of them, but we got replies, from four. In one of these provinces, the alcoholic is treated in the general hospital for one or two days, and then he has to be discharged, while in another province they won't take him in in the acute stage of alcoholism at all. They wait until he has sobered up, and then they take him in and he has to stay for two weeks. So, right across Canada there is no known best method of treating the alcoholic. We are studying the problem and we hope to come -- or that the Commission and the groups across Canada might come to something that may be better for the treatment of the alcoholic case. We feel in Riverside that we are not doing enough in our mental health institutions for the rehabilitation of the

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DR. McNEILL: I just wished to mention the problem of alcoholism -- and Dr. Maloney certainly has mentioned it very well: we have our problems here, perhaps more so than some of the other provinces of Canada with the alcoholic. The psychiatrists at Riverside are studying the problem. We were wondering how the other provinces are doing and what they are doing in the problem of the alcoholic patient. We felt perhaps the acute alcoholic should be treated at general hospitals, and this has never been done on Prince Edward Island; it would be a change. So, we wrote to the other provinces of Canada, and we didn't get replies from all of them, but we got replies, from four. In one or three provinces, the alcoholic is treated in the general hospital for one or two days, and then he was to be discharged, while in another province they wouldn't take him in an acute stage of alcoholism at all. They wait until he has sobered up, and then they take him in and he has to stay for two weeks. So, right across Canada there is no known best method of treating the alcoholic. We are studying the problem and we hope to come -- or that the Commission and the groups across Canada might come to something that may be better for the treatment of the alcoholic case. We feel in Riverside that we are not doing enough in our mental health institutions for the rehabilitation of the

alcoholic. We have to do more, but we have to know where we are going, and we have to study the problem to a larger extent than we have done previously.

COMMISSIONER BALTZAN: Gentlemen, I will be through very soon, and I think I will understand everything. Page ii, paragraph 7, diagnostic services: my question is that for patients requiring hospitalization there is no real question they did receive or have included all diagnostic services under their hospital scheme, so it is really not a question, but really confirmation.

DR. COADY: Yes.

COMMISSIONER BALTZAN: My important question is, what is your recommendation for patients not requiring hospitalization? They also must have these covering services? Do you want them also to have the benefits of these diagnostic services?

DR. MacNEILL: I might say, Mr. Chairman, in our hospital insurance program we cover now the out-patient for diagnostic services; we get x-ray and laboratory services and electrocardiograms, and anything needed in the diagnostic services.

COMMISSIONER BALTZAN: Thank you, Mr. Minister. Would you please explain what is the place of the organized clinics outside of hospitals with qualified personnel in this overall scheme? Must all your patients go to the hospital to obtain these diagnostic services, or can they be rendered by the clinics?

DR. LEA: I gather when you refer to clinics, we are talking of voluntary associations by private

[illegible]

where we are going, and we have to study the problem to a larger extent than we have done previously.

COMMISSIONER BASTEDO: Gentlemen, I will be [illegible]

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services: my question is that for patients requiring hospitalization there is no real question they did receive or have included all diagnostic services under their hospital scheme, so it is really not a question, but really confirmation.

DR. GOADY: Yes.

COMMISSIONER BASTEDO: My important question is, what is your recommendation for patients not requiring hospitalization? They also need a best range covering services. Do you have them also [illegible] the benefits of these diagnostic services?

DR. MacDONALD: I might say, Mr. Chairman, in our hospital insurance program we cover the out-patient for diagnostic services, we get x-ray and laboratory services and electrocardiograms, and anything needed in the diagnostic services.

COMMISSIONER BASTEDO: Thank you, Mr. Whitson. Would you please explain what is the place of the organized clinics outside of hospitals with qualified personnel in this overall scheme? Must all your patients go to the hospital to obtain these diagnostic services, or can they be referred by the clinics?

DR. LEA: I rather gathered you refer to clinics, we are talking of voluntary associations by private

practitioners grouped together for the practice of medicine. We are not referring to clinics in the other sense, that it is often used, of tax supported or government supported or otherwise supported groups. The clinics to which we refer here are purely associations of practitioners engaged in private practice, working together. There is no investigating work done and we have no laboratory facilities other than basic essentials.

COMMISSIONER BALTZAN: But you have electro-cardiograms, say?

DR. LEA: That is all covered under the Hospital Services Commission -- out-patient.

COMMISSIONER BALTZAN: Well, that is different from other places.

DR. LEA: If I may take a moment of your time to explain how that is covered, the Hospital Services Commission, when they became established offered diagnostic services and set up e.c.g. facilities in the various hospital out-patient departments. It became apparent this was going to be rather a cumbersome thing in that in this province we already had in three centres existing e.c.g. facilities in various doctors' offices. The Hospital Services Commission agreed to accept these doctors' offices and clinics as extensions of the out-patient department. Therefore, any e.c.g. which happens to be done in the clinic of which I am a member is considered as having been done in the hospital of which I am on the staff, and these e.c.g.'s are read by half a dozen qualified interpreters.

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COMMISSIONER BALTZAN: That is very important for us to know, because that does not obtain in other provinces.

DR. LEA: No, sir, and this has been worked out. I may say we have very happy relations with the Commission and with the Department of Health. It is a matter of convenience, it seems to us, to be in a position to have the e.c.g. done there rather than see the doctor bundle him off to hospital.

COMMISSIONER BALTZAN: I am very pleased to have this record for future reference.

Page 3 in the body of your brief, paragraph 14, the matter referring to your neurology consultants service from Halifax. My question 1: is this on a fee for service basis?

DR. LEA: No, sir, that is a service that is provided by the Department of Health.

COMMISSIONER BALTZAN: Is it on a per diem basis, for the day or the time spent?

DR. BECK: I am very closely associated with this as it is carried out within the mental health centre. This service is provided by the government; the neurologist is paid on an indemnity basis. It has been an excellent service and has been operated for six years. I have been associated with them for six years. It is steadily growing and providing an increase in the useful role for the practitioners of the province and for the patients of the province. It is very useful.

COMMISSIONER BALTZAN: Lastly, sir, is there a

[illegible]

DR. IDA: No, sir, and this has been brought out. I may say we have very happy relations with the Commission and with the Department of Health. It is a matter of convenience, it seems to us, to be in a position to have the e.c.g. done there rather than see the doctor bundle him off to hospital.

COMMISSIONER RAYLAW: I am very pleased to have this record for future reference.

Item 3 in the body of your letter, permanent service from Halifax. My question is, is this on a fee for service basis?

DR. LEA: No, sir, this is a service that is provided by the Department of Health.

COMMISSIONER RAYLAW: It is on a per diem basis, for the day on the time spent?

DR. LEA: I am very pleasantly associated with this as it is carried out within the public health centre. This service is provided by the government; the municipality is made to no burden, sir. It has been an experimental service and has been operated for six years. I have been associated with them for six years. It is a capability working and providing an increase in the medical role for the possibilities of the province and for the patients of the province. It is very useful.

COMMISSIONER RAYLAW: Lastly, sir, is there a

roster of neurologists or is there an appointed neurologist that gives this service?

DR. BECK: It is difficult to pinpoint that. We have a roster of two, and usually one of them comes over.

COMMISSIONER BALTZAN: Are there other neurologists available -- I don't mean here in this province -- who you call upon?

DR. BECK: No. Primarily the neurologist service is provided by the internal medicine people, and psychiatrists have a particular interest in this field, too. But there are no neurologists on the island.

COMMISSIONER BALTZAN: Thank you for the answers.

COMMISSIONER GIRARD: Mr. Chairman, I have two questions. My first question is directed to Dr. Coady, and it pertains to better utilization of nursing services. Dr. Coady, can you or one of your colleagues give us some suggestions of how we can better utilize nursing services, because we are interested in this field very much.

DR. COADY: Mr. Chairman, in reply to that, I believe you probably refer to my earlier remarks.

COMMISSIONER GIRARD: I did.

DR. COADY: And I had in mind at that time more the practitioner in the rural areas, many of whom for reasons best known to themselves, or some of whom, I should say, for reasons best known to themselves have not provided themselves with adequate

[illegible]

[illegible]

DR. BRUX: It is difficult to dispute that. We have a roster of two, and usually one of them comes [illegible].

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neurologists available -- I don't mean here in this province -- who you call upon?

DR. BRUX: Mr. Primarily the neurological service is provided by the internal medicine people, and psychiatrists have a particular interest in this field, too. But there are no neurologists on the [illegible].

COMMISSIONER BALLARD: Thank you for the [illegible].

COMMISSIONER GRANT: Mr. Chairman, I have two questions. My first question is directed to Dr. Coady, and it pertains to further utilization of nursing services. Dr. Coady, can you or one of your colleagues give us some suggestions of how we can interest [illegible] interested in this field [illegible].

MR. COADY: Mr. Chairman, in reply to this, I believe you probably refer to my [illegible] are [illegible].

COMMISSIONER GRANT: I did.

DR. COADY: And I had in mind at that time more the practitioner in the rural areas, many of whom for reasons best known to themselves, or some of whom, I should say, for reasons that known to themselves have not provided themselves with adequate

nursing staff in their offices to facilitate the rapid care of their patients and to lighten the burden on the physician. I don't think there is anything that any nursing organization can do to improve this situation. I think the first move will follow from the practitioners themselves.

With regard to in-hospital services, nursing services, I have no recommendations to make how their services could be improved.

COMMISSIONER GIRARD: Doctor, when you refer to practitioners and nurses in their offices, are you referring to general practitioners who would have registered nurses in their offices?

DR. COADY: Yes.

COMMISSIONER GIRARD: And do you think that is better utilization of nursing services?

DR. COADY: Well, I think that better health services can be provided by the physician's office which is staffed with a nurse in addition to the physician than can be provided by an office which is staffed by nurses only.

COMMISSIONER GIRARD: Would you have an idea how many, if your general practitioners wanted to get registered nurses in their offices, would you have enough nurses to go around?

DR. COADY: I don't think I am prepared to answer that question.

DR. MacMILLAN: Mr. Chairman, the only thing I would say about that is this, that there are many nurses who are married and living in small communities

nursing staff in their offices to facilitate the rapid care of their patients and to lighten the burden on the physician. I don't think there is anything that any nursing organization can do to improve this situation. I think the trend must will follow from the [illegible]

With respect to in-hospital services, nursing services, I have no recommendations to make how their services could be improved.

COMMISSIONER DIXON: Doctor, when you refer to practitioners and nurses in their offices, are you referring to general practitioners who would have registered nurses in their offices?

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COMMISSIONER DIXON: And do you think that is better utilization of nursing services?

DR. COADY: Well, I think that nursing health services can be provided by her professional office which is staffed with a nurse in addition to the physician than can be provided by an office which is staffed by nurses only.

COMMISSIONER DIXON: Would you have an idea how many, if your general practitioners wanted to get registered nurses in their offices, would you have enough nurses to go around?

DR. COADY: I don't think I am qualified to answer that question.

[illegible]

I would say about that is right, that there are many nurses who are married and living in small communities

who are not being utilized, and therefore you would make better use of nursing services.

COMMISSIONER GIRARD: You spoke of having no V.O.N. nurses in this province. Can you tell us the reasons why you have not any V.O.N. nurses in Prince Edward Island?

DR. MacNEILL: I may say what we do have first in the province. We have a public health nursing service in Prince Edward Island. We have 15 nurses who do public health work, and these nurses do our innoculation clinics and they do post-natal checkups of the mothers and the babies. They do any emergency service that we require. They do a lot of work in that regard. We do have social welfare bureaux, free on the island, which do provide some nursing services in the home. I investigated about a year ago about the Victorian Order of Nurses. That has never been started here. Apparently to my knowledge there has never been a request for it. I investigated it because somebody asked me why we didn't have it, and no nursing organization today has requested the Victorian Order of Nurses to my knowledge. The Victorian Order of Nurses, as you know, is in operation in some other provinces. I feel they could serve a very useful purpose here and could take care of some of the things in the welfare bureau and in the public services. While we don't have it, no organization has instigated the move.

COMMISSIONER GIRARD: The reason I brought this up, if I am correct, your public health nurses

who are not being utilized, and therefore you would make better use of nursing services.

COMMISSIONER GIRARD: You spoke of having no V.O.N. nurses in this province. Can you tell us the reasons why you have not any V.O.N. nurses in Prince Edward Island?

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COMMISSIONER GIRARD: The reason I brought this up, if I am correct, your public health nurses

do not provide bedside care.

DR. MacNEILL: We have Miss Mona Wilson here; she has been in our service for a number of years.

COMMISSIONER GIRARD: May I finish this? If I am correct, public health nurses do not give bedside care, and V.O.N. nurses are primarily for bedside care and teaching, education, but they could relieve some of your beds by giving bedside care.

DR. HOWATT: I will try to answer your question. First of all, our public health nursing division does not provide any bedside care, for several reasons: one, the shortage of staff; they have plenty to do now. Secondly, speaking of the V.O.N., in the seven years I have been working in the department there have been representatives from the V.O.N. twice in the province investigating the possibilities of setting up their organization here. The reason for their not coming here I am not familiar with; they have not given that information out. However, there are possible reasons for this. The V.O.N. primarily work in centres, and Prince Edward Island has no large centres, and perhaps their administration program would not work for that reason. We have considered, talked, wondered about the provision of bedside care in the province. It is just not feasible with our staff.

MRS. EDNA LA FLAIR: This is to be presented in our statement this afternoon regarding the lack of bedside nursing care being included in our public health nursing services.

[illegible]

DR. MACNEILL: We have Miss Mona Wilson here; she has been in our service for a number of years.

COMMISSIONER GIBARD: May I finish this? If I am correct, public health nurses do not give bedside care, and V.O.N. nurses are primarily for bedside care and teaching, education, but they could relieve some of your beds by giving bedside care.

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[illegible] V.O.N. primarily work in cities, but Prince Edward Island has no large centres, and therefore their administration program would not work for that [illegible] the provision of bedside care in the province. It is just not feasible with our staff.

MRS. EMMA M. MACKAY: This is to be presented in our statement this afternoon regarding the lack of bedside nursing care being included in our [illegible]

COMMISSIONER STRACHAN: Mr. Chairman, I think the Commission would like to know the position of the Board of Trustees at Riverside Hospital and its peculiar functions?

DR. MacNEILL: We appointed to our Board of Trustees two members from the government, that is not members of the government as such, but members of the Health, and they are elected by the party in power, and one opposition, and this, I believe, was a recommendation of the Mental Health Society. We have also tried to get coverage from the island. So we have a lady, Miss Lidstone from Summerside on the Board; she represents the ladies and the general public. We have Mr. Peter Gallant, who is a former school teacher. We have two members from the government side of the House, Mr. Myer and Mr. Dingwell, and Mr. Ross is the member from the opposite party. We also have --

COMMISSIONER STRACHAN: I am not thinking of individuals, names, I am thinking of the general setup of the Board of Trustees.

DR. MacNEILL: We have one member of the Medical Society, one lady, one former school teacher, two members from the government, one member of the opposition party, and then a Supervisor of the hospital.

COMMISSIONER STRACHAN: That makes up a board of seven?

DR. MacNEILL: I think it is eight.

COMMISSIONER STRACHAN: It is made up of lay and professional people?

DR. MacNEILL: Yes. It is a provincial

COMMISSIONER STRACHAN: Mr. Chairman, I [illegible] the Commission would like to know the position of the Board of Trustees at Riverside Hospital and its peculiar functions?

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COMMISSIONER STRACHAN: It is much up of lay [illegible]

DR. MacNEILL: Yes. It is a provincial

hospital; it is a little different from a hospital in the community.

COMMISSIONER VAN WART: Mr. Chairman, may I ask Dr. MacMillan through you, under the evolution of the extended benefit system which you have in your brief, do you still think there is a place for the present voluntary organizations to carry on, and I am speaking especially of the Red Cross and Tuberculosis groups and mental health groups, and so on? Do you still think there is a place as you evolve the extended benefit system?

DR. MacMILLAN: I presume you are asking my personal opinion?

COMMISSIONER VAN WART: Yes.

DR. MacMILLAN: I think this cannot be answered categorically, because these are part of an evolutionary program in Canada. I think there is a place for all voluntary organizations. The particular role they may assume from time to time may vary depending on the circumstances, and one example in Prince Edward Island may illustrate my point. The Tuberculosis League in Prince Edward Island initiated the mass x-ray program and financed it from voluntary means. At the present time it is now under the Department of Health, and they organized and took over that program from the voluntary Tuberculosis League and they have put their efforts to looking after the family in other ways. You mention the Red Cross. The transfusion service comes to our mind. But the role of these people who

hospital; it is a little different from a hospital in the community.

COMMISSIONER WARE: Mr. Chairman, may I ask Dr. MacMillan through you, under the evolution of the extended benefit system which you have in your brief, do you still think there is a place for the present voluntary organizations to carry on, and I am speaking especially of the Red Cross and Tuberculosis groups and mental health groups and so on? Do you still think there is a place as you create the expanded [illegible]

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initiate these programs is an integral part of our life and I think should be continued.

COMMISSIONER FIRESTONE: Mr. Chairman, I would like to first of all discuss briefly with the members of the Medical Society of Prince Edward Island the question of principle, the question of principle of providing extended medical services for the people of Prince Edward Island, and perhaps I may address my first question to Dr. Coady.

I take it you are familiar, sir, with the terms of reference of the Royal Commission as contained in our order-in-council. May I just recall one sentence and read it to you. The Commission is required "to recommend such measures, consistent with the constitutional division of legislative powers in Canada, as the Commissioners believe will ensure that the best possible health care is available to all Canadians..." The emphasis on the word "all" in the reference I take it is to the availability of universal coverage. Is your society in favour of a program or the development of a program which would provide the best possible health care services to all Canadians and which covers all citizens of Prince Edward Island?

DR. COADY: The answer is a definite yes, sir.

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COMMISSIONER FIRESTONE: Thank you very much. If I may go on with this question of principle. In your appendix B, you reproduce the statement of principles accepted by the C.M.A., and in that first principle you say: "That the highest standard of medical services should be available to every resident of Canada." Applying this principle to health services to be provided to every resident in Prince Edward Island, could you explain to us, in your own words sir, what your group has in mind when you speak of the highest standard of medical services available to every resident? What do you have in mind when you apply this principle to Prince Edward Island? Are you talking in terms of a comprehensive program? What have you in mind?

DR. COADY: Well, our proposal which we have made, as I understand it, and as it is intended to be understood, is that medical services should be made available to all citizens on the island. We propose that those who are financially able to pay the premium which would be required to insure themselves for these medical services will do so. We have proposed that there are some groups who will be unable to provide themselves, will be financially unable to provide themselves with this medical care insurance. We are proposing that those who are unable to contribute anything toward this should be assisted by a government to do so. Those, that is those who would require assistance in full. We will

COMMISSIONER FIRESTONE: Thank you very much. If I may go on with this question of principle. In your appendix B, you reproduce the statement of principles accepted by the C.M.A., and in that first principle you say: "That the highest standard of medical service is available to every resident of Canada." Applying this principle to health services to be provided to every resident in Prince Edward Island, could you explain to us, in your own words etc, what your group has in mind when you speak of the highest standard of medical services available to every resident? What do you have in mind when you apply this principle to Prince Edward Island? Are you talking in terms of a comprehensive programme? What have you in mind?

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agree that there is another group between those two, who will require assistance in part, and we are recommending a mechanism by which we would hope that this group, who will provide assistance in part to enable themselves to provide themselves with medical care insurance, that this assistance will be made available to them, and that with these three major groups covered we anticipate that all the citizens of Prince Edward Island will thereby have medical care insurance provided for them. Does that answer your question?

COMMISSIONER FIRESTONE: Would you say that the opportunity for good health is the right possessed by all citizens in Prince Edward Island?

DR. MALONEY: Mr. Chairman, we think this is highly desirable, and a thing for which we would aim, but we do not use the word right, because we do not think it is semantically pure. There are 36 definitions in the Encylopedia Britannica as to what is meant by right. Geometrical meanings, right angle, body meanings. We do not think this word should be used here at all. We think it is highly desirable, and like sin, we should constantly move toward the eradication of evil. We do not use the word right.

COMMISSIONER FIRESTONE: When you speak of the highest possible medical care, this is quite in line with what you say in paragraph 32, where you state:

"That the medical profession favours

agree that there is another group between those two, who will require assistance in part, and we are recommending a mechanism by which we would hope that this group, who will provide assistance in part to enable themselves to provide themselves with medical care insurance, that this assistance will be made available to them, and that with these three major groups covered we anticipate that all the citizens of Prince Edward Island will thereby have medical care insurance provided for them. Does that answer your question?

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COMMISSIONER FIRESTONE: When you speak of the highest possible medical care, this is quite in line with what you say in paragraph 32, where you

"That the medical profession favours

as wide a coverage of illness benefits as is economically feasible." Does this mean that you are in favour of a comprehensive medical service plan?

DR. MALONEY: This is another term I would like to define as we mean it. We talk about comprehensive as referring to the range of medical benefits. We favour a wide range of medical benefits, or in other words comprehensiveness, and we favour also universal availability.

COMMISSIONER FIRESTONE: Well, that is clear and forthright. Thank you.

COMMISSIONER McCUTCHEON: Do you favour a plan which will be compulsory, in other words, would you compel all citizens to join in this plan, or would they have an option?

DR. MALONEY: No, we wouldn't compel all citizens to join the plan. Those people who are capable of taking care of themselves, we think should be encouraged in all fields, and in medicine likewise. We would like to point out that when government monies are used to support in whole or in part this indigent group, this is not an infringement of liberty. The definition of liberty is the opportunity for a man to do what he considers is right. You should remain in good health, therefore when you assist in whole or in part a premium of a man who is unable to pay, you do not deny him freedom, you make it more easy for him to exercise that freedom.

COMMISSIONER FIRESTONE: Do you then consider

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COMMISSIONER FIRESTONE: Do you then consider

that a tax-supported plan is not compulsory in the term of definition that has been asked by my fellow commissioner?

DR. MALONEY: No sir, we do not think that such support has compulsion inherent in it.

THE CHAIRMAN: Do you concede the right of a person who is able to pay for himself to stay out of the plan?

DR. MALONEY: Yes sir, we do.

THE CHAIRMAN: What about the person who is not able to pay. Has he the same right to stay out as the other?

DR. MALONEY: This is the difference between right and licence.

THE CHAIRMAN: No, but I mean to say, in the working out of your program, how would, somebody who cannot afford it, is he just going to be able to say I don't want to belong to it either?

DR. MALONEY: I think you could take a very good simile in the hospital commission services in hospitalization, where these people are enrolled if they are indigents, and they are paid for.

THE CHAIRMAN: No, but this man does not want to be enrolled.

DR. MALONEY: I think if any man does not want to have money spent on himself for his benefit, he should be retained as such as a unique speciman.

DR. MacMILLAN: In the case of a man, for example, who refuses to be enrolled, and thereby protect his wife and family, then I think something

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else comes in, a prior right of theirs, over which he has no control.

THE CHAIRMAN: Dr. MacMillan, I don't mind the humour, but I think we have to face it beyond the humour if we are speaking of the right of an individual to stay out of a program. Are you going to limit that only to one who has money?

DR. BECK: It seems to me that this is not a problem unique to medicine.

THE CHAIRMAN: I wouldn't think so.

DR. BECK: We face this in the child welfare field, and I think it becomes not a problem of medicine, but a problem of the courts. It involves neglect, and this is the approach that should be taken to this problem.

DR. COADY: It would seem to me that we would talking about a very, very minority group when you talk about such a group as you outline, because I believe that if this proposition is put to the general population of this province, or any other area, and if particularly the poorer people are properly approached, and are made to see what benefits can be derived by them from participation in such a proposal, that the vast majority would participate, but there might conceivably be a very minority group who wouldn't.

COMMISSIONER FIRESTONE: I take it, Dr. Coady, that you feel that if such a comprehensive plan has been provided for, including coverage for those who cannot afford it, whether this particular person wishes

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COMMISSIONER MACRSTONE: I take it, Dr. Goady, that you feel that if such a comprehensive plan has been provided for, including coverage for those who cannot afford it, whether this particular person wishes

to use the plan or not it is up to him as far as it has been provided, is that your thought?

DR. COADY: That is our proposal, yes.

COMMISSIONER FIRESTONE: That is the principle on which you base your proposal?

DR. COADY: Yes.

COMMISSIONER FIRESTONE: If I may proceed, Mr. Chairman. My next question relates to paragraph 16 on page 4. Dr. Coady, we touched briefly before on group clinics composed of physicians working in voluntary association. Would you or one of your associates explain how these group clinics work?

DR. LEA: Mr. Chairman, in the province sir there are four clinic groups. One in Summerside, one in O'Leary, which is a group of people practicing in a small rural community, and two in Charlottetown. The principle on which we all operate, and I can best speak for my own group, is the group which, as far as the financial, but as far as we are concerned we are full partners. The expenses are paid and that is that. As far as the professional aspect of this is concerned, I think this is most important, that people in this province tend to adopt me or anybody else as their doctor. They will come to me, I am an internist, but they will come to me with their broken legs and whatnot, but they expect me, in doing my best for them, to turn them over to the person who is going to do the best for that patient. I think I am coming to this same thought, sir, and I would say that in the type of practice that we do in this

to use the plan as one it can be in [illegible] and been practice, is that you think.

DR. COADY: That is our proposal, yes.

COMMISSIONER FIRESTONE: That is the principle on which you base your proposal?

DR. COADY: Yes.

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1 province, perhaps one out of every three, I think it
2 is fair to say that a third of the patients who come
3 to our clinic will end up in somebody else's hands.
4 They may come to me because they know me, or I have
5 done something in the past, or any one of my colleagues,
6 but they will end up, and I may say sir that they
7 appear to be quite happy with that distribution.
8 And one of two things will happen the next time
9 something is wrong. No matter what it is, they may
10 attach themselves to the last person who saw them, or
11 if my personality is stronger, they might bounce back
12 to me. The value that we see in that, sir, is the
13 ready availability of informal consultations, and one
14 hesitates to mention the ugly term of the value of
15 money, but the value of the free consultations that
16 go on in any one of our clinic groups is phenomenal,
17 and every afternoon there is a very high percentage.
18 The other thing is this, that in this province you
19 will have noted that we do have a relatively high
20 percentage of specialists. You will have noticed,
21 I think, that there are 33 specialists. It is
22 peculiar perhaps to this province, perhaps because we
23 are small and everybody knows that with the exception
24 of a pure specialist, gynaecologists and so forth or
25 what not, most specialists have to do a little general
26 practice for various reasons, because of public
27 relations, or because you just cannot get out of it,
28 but that is the pattern of practice, that the
29 specialists, we feel we are very well covered with
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forced to live on referred cases, simply there is not that volume of work.

COMMISSIONER FIRESTONE: This is a very helpful explanation. Do I understand, if I may continue this type of questioning a little bit further, do I understand that your clinic shares both the expenses and the income that is left after paying the the expenses?

DR. MALONEY: I can only speak for one-quarter of the clinic groups. As you undoubtedly know, there are many ways that this type of administrative setup can be worked out. That is one method with which I am familiar.

COMMISSIONER FIRESTONE: You refer many of the cases that require specialist treatment to some of the specialists, are these specialists members of your group?

DR. MALONEY: The answer to that is that in at least the two groups in Charlottetwon, practically all the members of both groups are specialists. We do carry on a collosal amount of general practice, which accounts of course for the fact that the high percentage of the patients who come through our doors end up with another physician.

COMMISSIONER FIRESTONE: Therefore, your clinic consists of people who perform general medical practice as well as medical services in specialized fields?

DR. MALONEY: That is right.

COMMISSIONER FIRESTONE: It is a team working

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COMMISSIONER FIRESTONE: It is a team working

together?

DR. MALONEY: That is right.

COMMISSIONER FIRESTONE: And because of that team approach, you are able to offer better service to your patients?

DR. MALONEY: I feel, as an internist, I am not going to harm a patient by performing a minor surgical procedure, which perhaps some other member of the group could do a little better.

COMMISSIONER FIRESTONE: Would you say that as a result of this development of the clinic approach, which is a cooperative effort of a group of doctors, physicians, would you say that this is a reflection of the changing type of medical practice of the times, because of greater dependence on specialist services?

DR. MALONEY: Yes, the answer is yes. This has gradually evolved, but it is not in any sense, even in this community where we have two clinic groups, totalling 18 physicians, we have not been in any sense displacing the man in private practice, and I would like to elaborate on that, that there are patients, and I sympathize fully with their point of view, who prefer to go with a man in private practice than to come to a clinic.

THE CHAIRMAN: When you refer to a man in private practice, do you mean in solo practice?

DR. MALONEY: Yes, in solo practice, but there may be many factors there. The large, impersonal waiting room may be a factor and there are others. But we do find in no sense do we run the solo

cooperative

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[illegible]

may be many doctors there. The large, impersonal waiting room may be a factor and there are others. But we do find in no sense do we run the solo

practitioner into the ground by the mere fact of the bigness of the clinic groups.

COMMISSIONER FIRESTONE: But to speak in the terms of the trend of treatment with the growth of the specialist and better medical services are provided by referral to people in specialized fields?

DR. MALONEY: Yes, in my opinion we have to agree.

COMMISSIONER FIRESTONE: Therefore the answer to that question is yes?

DR. MALONEY: Yes.

COMMISSIONER FIRESTONE: Therefore, if we are moving in this direction, or a personal relation between a doctor who looked after a person from the day he was born until the day he died is changing?

DR. MALONEY: I think it is changing,and it is changing slowly in a rather stable community such as this whole province. It is changing slowly, but the evolution as it is taking place, I think sir, has to be considered in the interest of the patient.

COMMISSIONER FIRESTONE: Oh, yes. I take it from what you have been saying, sir, that your referral from one man who is more or less a general practitioner to a specialist takes place in the interest of the good health of the patient?

DR. MALONEY: Yes, that is true, and if the patient does not like the second man, he always comes back to the first and says he doesn't like him.

COMMISSIONER FIRESTONE: I presume if the first man was a general practitioner he would refer him

[illegible]

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COMMISSIONER MINSTONE: But to speak in the terms of the trend of treatment with the growth of the specialist and better medical services are providing by referral to people in specialized fields?

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COMMISSIONER MINSTONE: Then I have the answer to that question is yes?

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COMMISSIONER MINSTONE: Therefore, if we are moving in that direction, or a personal relation between a doctor and looked after a person from the day he was born until the day he died is disappearing

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[illegible] from what you have been saying, sir, that your material from one man who is more or less a general practitioner to a specialist takes place in the interest of the good health of the patients?

DR. MALONEY: Yes, that is true, and if the patient does not like the second man, he always can go to the third and maybe he doesn't like him.

COMMISSIONER MINSTONE: I presume if [illegible] than the a general practitioner he would refer a

to another specialist?

DR. MALONEY: That is right.

DR. BECK: As an outsider to the clinic, I would like to make a comment. I think perhaps the simplest way to answer it is that Dr. Lea's own practice makes the answer to your question no. That within his practice, within this clinic there is an intense personal physician relationship set up, and I can testify to that, because I see his patients outside of the clinic.

COMMISSIONER FIRESTONE: Well, don't you think that your colleague can speak for himself?

DR. BECK: I thought that this observation might be helpful to you. I am not contradicting him. I am just bringing a different viewpoint out.

DR. GRANT: I too belong to a clinic in a town fifty miles from here, and I am in association with a physician, and we voluntarily associated ourselves together for the benefit of the patient. Prince Edward Islanders are very loyal people, and loyal to their doctors, and their doctor-patient relationship is very carefully preserved, and as Dr. Lea, a member of a Charlottetown clinic, says, that many patients come to him as an internist with their broken legs and all other kinds of problems. The same thing you see in our clinic in Summerside, where we have four specialists and a number of general practitioners, and we feel that we are able to give a better kind of service to our patients by an association of ideas, and by our free transmission

to another specialist?

DR. MALONEY: That is right.

DR. BROWN: As an outsider to the clinic, I [illegible] simplest way to answer it is that Dr. Lewis's own practice makes the answer to your question no. That within his practice, ultimately clinic there is an intense personal objection relationship set up, and I can readily see that, because I see his patients [illegible]

COMMISSIONER BIRCHFIELD: Well, don't you [illegible] might be helpful to you. I am not criticizing, but I am just bringing a different viewpoint.

DR. GRAY: I too [illegible] from fifty miles from here, and I am in association with a physician, and we voluntarily associated ourselves together for the benefit of the patient. Those Eastern Islanders are very loyal people and loyal to their doctors, and their doctor-patient relationship is very carefully preserved, and as Dr. Lee, a member of a Charlottetown clinic, says, that many patients come to him as an internist with their broken legs and all other kinds of problems. The [illegible] thing you see in our clinic in Summerside, where we have four specialists and a number of general practitioners, and we feel that we are able to give a better kind of service to our patients by co-ordination of ideas, and by our free interchange

of patients from one office to the other, depending on which category he happens to belong. We do not interfere with the man in solo practice. We have every respect for him and do everything we can to see that his interests are not encroached upon, and these men often come to us for advice as to carry out certain procedures. There is nothing in our clinic, or the ones in Charlottetown, to interfere with the doctor-patient relationship, and we feel that we are doing an excellent service in the promotion of the better medicine for all our people on the Island.

COMMISSIONER FIRESTONE: I take it, sir, that the referral that does take place takes place in the interests of the patient?

DR. GRANT: That is perfectly true, sir.

DR. MacMILLAN: Just by way of explanation to something which Commissioner Firestone said with regards to service within the clinic. We have no eyes, ear, nose and throat man, and no ophthalmogist. Dr. Lea's clinic has the three of them and we send all our patients to his clinic.

COMMISSIONER FIRESTONE: In other words, there is a great degree of cooperation, and you do not feel that this interferes in any way with the happy patient-physician relationship?

DR. MacMILLIAN: That is right.

on which category he happens to belong. We do not interfere with the man in solo practice. We have every respect for him and do everything we can to see that his interests are not encroached upon, and these men often come to us for advice as to carry out certain procedures. There is nothing in our [illegible] with the doctor-patient relationship, and we feel that [illegible] promotion of the better medicine for all our people [illegible].

COMMISSIONER FIRESTONE: I take it, sir, that the referral that does take place takes place in the interests of the patients?

DR. [illegible]: That is perfectly true, sir.

DR. MacMILLAN: Just by way of explaining it to something which Commissioner Firestone said a [illegible] regards to serving w [illegible] the clinic. We have no eyes, ear, nose and throat man, and no [illegible] Dr. Lea's clinic has the three of them and we send all our patients to his clinic.

COMMISSIONER FIRESTONE: In other words, there is great degree of cooperation, and you do not feel that this interference in any way with the proper patient physician relationship

DR. MacMILLAN: [illegible]

COMMISSIONER FIRESTONE: May I turn to paragraph 21 on page 6, sub-paragraph 5: we have discussed this question of directing physicians to low income rural areas before. I am just wondering whether the association would endorse a proposal which would involve offering a financial incentive to a physician going into rural areas?

DR. COADY: In reply to that, I don't think we have any really crystallized ideas as to what these incentives might be that would attract a physician to an area.

COMMISSIONER FIRESTONE: Would it be possible, Dr. Coady, for you and your associations to give some thought to this matter, because the question of getting physicians into the rural areas is quite an important one. It is important in your province and in other provinces, and what this Commission is concerned with is to find ways and means by which this can be achieved. Maybe you have some concrete thoughts on this matter, and if you do, would it be possible for you to make them available to us in written form on a subsequent occasion?

DR. DEWAR: Mr. Chairman, I happen to practice in a small rural community, and I did practice there alone for seven years, and it had been a one man practice for at least twenty-five years before that, and the idea wasn't wrong, but it would only support one doctor. I would like to say we set up a clinic there, and at the present time we have two other general practitioners in the clinic and

COMMISSIONER FIRESTONE: May I turn to paragraph 21 on page 6, sub-paragraph 5: we have discussed this question of attracting practitioners to low income rural areas before. I am just wondering whether the association would endorse a proposal which would involve offering a financial incentive [illegible]

DR. COADY: In reply to that, I don't think we have any really crystallized ideas as to what those incentives might be that would attract a practitioner [illegible]

COMMISSIONER FIRESTONE: Would it be possible, Dr. Coady, for you and your associations to give some thought to this matter, because the question of getting physicians into the rural areas is quite an important one. It is important in some provinces [illegible] province, and what this Commission is concerned with is to find ways and means by which this can be achieved. Maybe you have some concrete thoughts on this matter, and if you do, would it be possible for you to make them available to us in written form as a subsequent consideration?

DR. DEWAR: Mr. Chairman, I happen to practice in a small rural community, and I do practice there alone for seven years, and it had been a one man practice for at least twenty-five years before then, and the idea wasn't wrong, but it won't only support one doctor. I would like to say we set up a clinic there, and at the present time we have two other general practitioners in the clinic on

a surgical confrere who does nothing but surgery. These men are all practicing medicine, and they are all fairly well satisfied with practising it in the rural community, and I think one of the prime factors in getting them set up and started was, of course, financial. They were assured of a certain financial income and they didn't have to start off for the first five or six years on a shoestring. For that reason there has been quite a harmonious relationship and satisfaction among the members of the group.

DR. COADY: In reply to your question, I think we can assure you we would be glad to try and carry out further studies on that, and give you a further submission.

DR. MALONEY: Mr. Chairman, some of the things which come under that are, for instance, the problem we talked about or touched upon previously -- transportation. When a young man leaves medical school, a high percentage of them owe a lot of money, and to go into an area in this province you really need a car or a jeep or a snowmobile or even a helicopter. To expect a person to finance this is impossible. On the other hand, when a man gets into his fifties he is not able to go out in the storms as he was when he was young. So, he tends to leave the community. Now, to say that transportation is the cause or responsibility of medicine, I think, is a mistake. This is the responsibility of the community basically. That is transportation.

The second thing is that it may be that in

a surgical conference who does nothing but surgery.

[illegible]

all fairly well satisfied with practising. It is the rural community, and I think one of the prime factors in getting them set up and starved was, of course, financial. They were assured of a certain financial income and they didn't have to start off for the first five or six years on a shoestring. For that reason there has been quite a harmonious relationship and satisfaction among the members of the group.

DR. GOADBY: In reply to your question, I think we can assure you we would be glad to try and carry out further studies on that, and give you a [illegible]

DR. MALONEY: Mr. Chairman, some of the [illegible] which come under that one, for instance, the problem of transportation. When a young man leaves medical school, a high percentage of them are a lot of money, and to go into an area in this province you nearly need a car or a jeep or a snowmobile or even a helicopter. To expect a person to have to think [illegible]. On the other hand, when a man gets into his [illegible] he is not able to go out in the morning, or was [illegible] he was young. So, he tends to leave the country [illegible] to see what transportation is the [illegible] responsibility of medicine, I think, in a district. That is the responsibility of the community [illegible].

The second thing is that it may be that in

these areas that are not able to support a doctor they might be subsidized to some extent. This would be one of the areas where an agency or tax supporting money could be used to raise the standard of medicine in the area and bring a doctor in.

The third thing is one of the reasons why doctors don't go into some of these smaller communities, and that is the lack of aids for the practice of medicine. They have been trained to practice scientifically, and they go into an area where there are no facilities whatever. The providing of these facilities, or making them nearer, would be a help.

Another item would be perhaps the provision of quarters in the area, so that a man coming out in debt would not have to build or buy a house.

These are four of the things we thought of.

COMMISSIONER FIRESTONE: You have presented us with an excellent outline of some of the things that could be done, and if that outline could be discussed amongst your members and put into concrete proposals, it would be of particular help to this Commission.

DR. COADY: Very good, sir.

COMMISSIONER FIRESTONE: If I may turn to page 7, paragraph 23: I take it your association, "has been active in the promotion of prepaid medical care plans on a non-profit basis for many years." When you are speaking of prepaid medical plans in this submission of yours, sir, on subsequent occasions,

these areas that are not able to support a doctor they might be subsidized to some extent. This [illegible] supporting money could be used to raise the standard of medicine in the area and bring a doctor in.

Doctors don't go into some of these smaller communities, and that is the lack of aids for the practice of medicine. They have been trained to consider economically, and they go into an area where there are no facilities whatever. The provisioning of these facilities, or making them present, would be a help.

Another item would be perhaps the provision of quarters in the area, so that a man coming out at night would not have to build or buy a house.

These are four of the things we thought of, ie with an excellent outline of some of the things that could be done, and if this outline could be discussed amongst your members and the Inter-Martin's proposals, it would be of particular help to this Commission.

DR. CRAMER: Very good, sir.

COMMISSIONER FIRESTONE: If I may turn to page 7, paragraph 2(i): I take to your credit, sir, this been active in the promotion of prepaid medical care plans on a non-profit basis for many years. When you are speaking of prepaid medical plans, in the

are you referring to medical care plans on a non-profit basis, as you mention in paragraph 23?

DR. COADY: Yes, I believe we are referring in most of our future remarks, to this type of a plan -- a non-profit voluntary plan, and in this case we are speaking about those that were sponsored by the medical profession.

COMMISSIONER FIRESTONE: I take it, then, that you are not holding a brief for commercial carriers, whether they are insurance companies, casualty companies, etc.; but you are basing your proposals, as you say here, on prepaid medical care plans, on a non-profit basis?

DR. MALONEY: I don't think that follows. We are holding no brief pro or con for the commercial carriers, but when we say a non-profit organization this does not necessarily mean a voluntary agency, one of the ones we have been sponsoring. It may mean a cooperative group or a farmers union; it may be some of the commercial companies, or Mutuals, if they could qualify under the regulations set down as a non-profit group.

COMMISSIONER FIRESTONE: But I take it you are referring to non-profit groups as distinct from profit groups; is that right?

DR. MALONEY: As distinct from profit groups, yes.

COMMISSIONER FIRESTONE: And therefore, all your proposals are based on suggestions for a prepaid medical care plan on a non-profit basis?

DR. GOADY: Yes, I believe we are referring in most of our future remarks, to this type of a plan -- a non-profit voluntary plan, and in this case we are speaking about those that were sponsored by the medical profession.

COMMISSIONER FINEGTOWN: I take it, then, that you are not holding a brief for commercial carriers, whether they are insurance companies, casualty companies, etc., but you are backing your proposals, as you say here, on prepaid medical care plans, on a non-profit basis?

DR. GOADY: We are holding no brief pro or con for the commercial carriers, but when we say a non-profit organization this does not necessarily mean a voluntary agency. One of the cases we have been approaching, it may mean a cooperative group or a farmers union; it may be some of the commercial companies, or Medicare. It could qualify under the regulations set down for a non-profit group.

COMMISSIONER FINEGTOWN: Now I take it you are referring to non-profit groups as distinct from medical societies.

DR. MILLER: As distinct from medic societies.

COMMISSIONER FINEGTOWN: And therefore, do your proposals are based on suggestions for a typical medical care plan on a non-profit basis.

DR. COADY: That is right. Those are the types of plans which we have sponsored.

COMMISSIONER FIRESTONE: And those are the plans you are recommending for adoption in future even on an expanding basis?

DR. COADY: Yes, but not necessarily to the exclusion of the profit plan.

COMMISSIONER FIRESTONE: In other words, you have no recommendation with respect to commercial carriers. Your recommendations concern themselves only with the non-commercial carriers?

DR. COADY: Yes, primarily.

COMMISSIONER McCUTCHEON: You said: "non-profit". Now, you are saying "non-commercial". Will you include in non-profit -- and I think your colleague suggested he would -- the Mutual commercial carriers -- no shareholders, no dividends?

DR. MacMILLAN: I think we are mixing up our terms a little bit. We are using "commercial carriers" to mean the old line insurance company; there is no question about it.

COMMISSIONER McCUTCHEON: Many of which are Mutual?

DR. MacMILLAN: Yes, and Commissioner Firestone asks this question, and I think what he is trying to get at is, would we have anything to say about companies who obviously make use of certain phases of health services for profit purposes only. If our proposal were carried out we would suggest that the Department of Insurance, or some other agency of

DR. COADY: That is right. These are the types of plans which we have sponsored.

COMMISSIONER FIRESTONE: Are these are the plans you are recommending for adoption in Jamaica even on an expanding basis?

DR. COADY: Yes, but not necessarily to the exclusion of the profit plan.

COMMISSIONER FIRESTONE: In other words, you have no recommendation with respect to commercial carriers. Your recommendations concern non-profit

[illegible]

COMMISSIONER MCCUTCHEON: You said, "non-profit". Now, you are saying "non-commercial". [illegible] you include in non-profit -- and I think your [illegible] has suggested as much -- the mutual [illegible]

[illegible]

DR. MCCULLAGH: I think we are making [illegible] our terms a little bit. We are using "commercial" [illegible] is no question about it.

COMMISSIONER MCCUTCHEON: Many of [illegible]

[illegible]

[illegible] this question, and I think must be [illegible] to get at it, would we have anything to say about companies who civilmanly make use of [illegible] health services for profit purposes only. If our proposal were carried out we would suppose that the Department of Insurance, or some other agency of

government which in some way controls this now, might set certain standards, and perhaps by way of example they might say that a company may qualify which, in fact, paid out 85 per cent of its premiums for services -- that they might qualify. If this type of set-up were possible we would have nothing against the persons or individuals or groups who carried it out. It may be a union or a coop or anything else. We would, however, be against the provision of companies being able to try to milk off the high premium groups and the good utilization groups. If they were to do this, they would have to be prepared to offer their services either to the whole public or to the group of people for whom they speak, such as a union. The unions may operate for themselves, and we would not have any complaint about that, but if they went into the public field, they would not be able to say, "We will only take you and you and you". They would have to offer it to the public as a whole on some readily available arrangement. We would not exclude any type of carrier which would meet the conditions which we think ideal.

COMMISSIONER FIRESTONE: If I may pursue this question a little further, Dr. MacMillan, would you be in favour of old line insurance companies undertaking plans in the province of Prince Edward Island irrespective of the proportion which they returned to the insured?

DR. MacMILLAN: We would not be in favour of that. We would use the Argus chart and very

overmen, which in some way controls this now, might set certain standards, and perhaps by way of example [illegible] fact, pain out of per cent of the premiums the service -- that they might qualify. If this type of set-up were possible we would have nothing against the persons or individuals or groups who carried it out. It may be a union or a coop or anything else. We would, however, be against the provision of companies being able to try to milk off the high premium groups and the good utilisation groups. If they were to do this, they would have to be prepared to offer their services either to the whole public or to the groups of people for whom they speak, such as a union. The unions may operate for themselves, and we could not have any complaint about that, but if they want to be one public field, they would not be able to say, "I'll only take you and you and you." They would have to offer it to the public as a whole or some reasonable arrangement. We would not certainly be type of carrier which would test the conditions which we think there.

CHAIRMAN: Mr. [illegible] This question a little for her, Mr. McMillan, would you be in favour of an item the insurance companies undertaking plans in the province of Prince Edward Island irrespective of the proportion which they returned to the insurers?

DR. McMILLAN: We would not be in favour of that. We would use the usual and very

definitely tick off some of the companies not operating as we think they should be. This is the only reason medicine got into this work. Nobody did the work the voluntary plans are doing now. If people had given the type of programs which the voluntary plans are giving now, probably the non-profit plans might never have got started.

COMMISSIONER FIRESTONE: Therefore, if commercial carriers were to operate in Prince Edward Island a plan which would carry the endorsation of your group you would want to have a maximum proportion returned to the people who pay the insurance?

DR. MacMILLAN: Yes.

COMMISSIONER FIRESTONE: And that maximum proportion would be determined by whom?

DR. MacMILLAN: I think that, certainly, the government would have the right to determine who gets a license to run this type of plan. I think this is reasonable. It is done in utilities and other phases of operation. I think we would like to have someone to say with regard to the portion of the premiums which would be allocated to pure medical services. We would not want them to be adversely affected by Dr. Maloney's snowmobiles and transportation.

COMMISSIONER FIRESTONE: That leads us to a question on paragraph 81 on page 23 which deals with alternative methods of financing such a plan. May I address the question to Dr. Coady. Paragraph 81, page 23: you point out, sir, that there are two alternative plans: one is all persons of the

[illegible]ntirely took off some of the compulsion out operations as we think they should be. This is the only reason medicine got into this work. Nobody did the work the voluntary plans are doing now. If people had given the type of programs which the voluntary plans are giving now, probably the non-profit plans might never have got started.

commercial carriers were to operate in Prince Edward Island a plan which would carry the cost, roughly of your group you would want to have a maximum percentage returned to the people who pay the insurance?

COMMISSIONER FINLAYSON: And that raises proposition would be determined by whom?

DR. GRIMMIAN: I think that certainly the government would have the right to determine who is a license to run this type of plan. I think this is reasonable. It is done in institutions and other places of operation. I think we would like to have something to say with regard to the portion of the premiums which would be allocated to pure medical services. We would not want them to be adversely affected by the Medicare's responsibilities and transportation.

COMMISSIONER FINLAYSON: That leads us to a question on paragraph 81 on page 27 which works with alternative methods of financing such a plan. May I address the question to Dr. Geary. Paragraph [illegible] page 27: you point out, sir, that there are two alternative plans: one is all persons of the

community are pooled as a single group risk; that is, all ages, the sick, the well, the infirm and the uninsurable, and a community rate struck for the total population. You say you are in favour of this sort of rate and this sort of policy; is that correct?

DR. COADY: That is right.

COMMISSIONER FIRESTONE: Now, if some of the insurance companies are not prepared to offer -- or the casualty companies or other private companies -- are not prepared to offer this sort of health service protection for citizens of an area, what would be your answer -- but that they are prepared to offer on a risk basis as they see fit, for example, excluding people 60 years and over?

DR. COADY: I think, Mr. Chairman, that such an insurance carrier would have to be excluded from the competitive field.

COMMISSIONER FIRESTONE: How would you put such a plan into effect?

DR. MacMILLAN: What we envisage is this: we envisage, as shown in the statement of our policy, that not only are we professionals providing to the people of Canada the quality of service that only we can provide, but we have said also that we should attempt -- professional and others -- to make the insurance mechanism available to all citizens. What we envisage is if we accept this principle, and then we would set up certain standards for carriers who are willing to make their services available to all of

[illegible]

all ages, the sick, the well, the infirm and the uninsurable, and a community rate struck for the total population. You say you are in favour of this sort of rate and this sort of policy; is that [illegible]

[illegible]

COMMISSIONER FITZGERALD: Now, it seems to me the insurance companies are not prepared to offer -- or the casualty companies or other private companies -- are not prepared to offer this sort of health service protection for citizens of an area, work would be your answer -- but that they are prepared to offer on a risk basis as they see fit, for example, excluding people 60 years and [illegible]

[illegible] an insurance carrier would have to be excluded from the compulsitive field.

COMMISSIONER FITZGERALD: How would you put such a plan into effect?

MR. MACKLIN: Here we envisage a three-way arrangement, as shown in the framework of our policy. That for duty are we professionals according to the people of Canada the quality of service that well, we can provide, but we have said also that we should attempt -- professional and others -- to make the insurance mechanism available to all citizens. This we envisage is if we accept this principle, and then we would set up certain standards for carriers who are willing to make their services available to all if

the people without restrictions, these restrictions would have to be eliminated. They would have to offer them to groups of individuals and to fulfill certain characteristics set down by the Department of Insurance or any other government agency as an acceptable character. Having done that, and having struck the community rate, then they should sell this to anybody they liked provided they fulfill these things. If one could sell it for 20 cents a month cheaper than anybody else, I think the higher fellow should have a look at his figures. We are thinking of setting up standard benefits, universal coverages and a selection of carriers.

COMMMISSIONER FIRESTONE: You say in paragraph 29 on page 8 that you have developed with your confreres from New Brunswick a medical service insurance on a service basis: can you elaborate the service basis to us? What does the service cover?

DR. MacMILLAN: The reason I am answering is because I have been very intimately associated with the Maritime Hospital Service Association since it started. The service program which we have formed is limited to two groups. First of all, those groups which are sold on a nationally syndicated basis by the members of Trans Canada Medical Plans. An example is the railroad contract: in this contract the railroads, union and management, have asked certain benefits be included, and our profession has said that we as participating physicians will give these services on a basis of payment from the plan as taken in full

[illegible] to be eliminated. They would have to [illegible] certain characteristics set down by the Department of Insurance or any other government agency as an acceptable character. Having done that, and having shown the community rate, then they should sell this to anybody they felt qualified that fulfill these duties. If one could sell it for 20 cents a week cheaper than anybody else, I think the insurance fellow should have a look at his figures. We are thinking of setting up standard benefits, underwriting coverages and a selection of carriers.

COMMISSIONER FIRESTONE: You say in paragraph 29 on page 8 that you have developed [illegible] service basis to day. What does the service county [illegible]

DR. MCMILLAN: The reason I am speaking is because I have been very intimately associated with the Maritime Hospital Service association since it started. The service program which we have formed is limited to two groups. Many of all, those groups which are said on a noncommercial specialized basis by the members of these groups medical plans. An example is the railroad community. In this community the railroads, union and management, have taken certain benefits be included, and our production has said that we as participating physicians will give these services on a basis of payment from the plan as taken in full

without any extra billing. There are some limitations of benefits, but these are union negotiated contracts and consequently they were given to us as a specification to meet.

The second group is this type of principle which we try to promote on our own within the area. Basically, without going into too much detail this consists of this: full coverage for all in and out of hospital, medical benefits on a general practitioner's level with complete medical, surgical and obstetrical and other consultations in and out of hospital, and when the patient goes to a specialist direct of his own choosing, then he may have to pay the difference between what the plan pays to a general practitioner and what that particular specialist may charge. If he is referred, the specialist is paid in full. In brief, that is it.

COMMISSIONER FIRESTONE: Do I take it that your Association prefers a service type of contract to the indemnity type of contract?

DR. MacMILLAN: Yes, sir. This is 100 per cent at low income level. It is the only possible one.

COMMISSIONER FIRESTONE: Can you explain to us why you prefer the service type to the indemnity types?

DR. MacMILLAN: Well, briefly, it is simply this, that the plan and the profession try to offer the patient a service. A service does not have a mathematical value in itself. It has an arbitrary value. Therefore, if we can provide the service and

[illegible]s, but these are when negotiated contracts [illegible] subsequently they were given to us as a [illegible]

The second group is this type of partnership which we try to promote on our own within the area. Basically, without going into too much detail this consists of this. This coverage for all in and out of hospital medical benefits on a second preferential level with complete medical, surgical and obstetrical and other consultations in and out of hospital, and when the patient goes to a specialist direct of his own choosing, then he may have to pay the difference between what the plan pays to a general practitioner and what that particular specialist may charge. If he is referred, the specialist is [illegible] in full, that is it.

COMMISSIONER FLEMMING: Do I read in that your association provides service type of coverage to the Ludermity type of contract?

DR. MACMILLAN: Yes, sir. This is 100 per cent at low income level. It is the only possible way.

COMMISSIONER FLEMMING: Do you see any [illegible] as why you offer the service type to the Ludermity [illegible]

DR. MACMILLAN: Well, briefly, it is that, that the plan and the professions try to give the patient a service. A service does not have a monetarial value in itself. It has an intrinsic [illegible]. Therefore, if we can provide the service we

make sure the patient does not have to pay anything extra we feel that is a much better arrangement than any program of indemnity. The reason indemnity had been used by our plan was that at a time in its history this was the only thing that could be done, and we thought it was much better than no plan at all.

COMMISSIONER FIRESTONE: Have most commercial carriers got indemnity plans or indemnity type contracts, or service type contracts?

DR. MacMILLAN: In fairness, they have both. They have entered the service fields in certain areas in which they offer to pay provincial tariff of an association for certain specified groups. They have not offered to the public at large any service program.

COMMISSIONER McCUTCHEON: Is it fair to say the service type program will only operate properly if it has the full support of the medical profession in the area?

DR. MacMILLAN: It must not only have the full support; it must have terminal guarantee of rendering a service even if in the terminal instance there may be no money to pay for it. It is inherrent that if the plan stops at any given time, the services already given are guaranteed by the physician without pay.

[illegible] does not have to pay anything extra as [illegible]

[illegible] been used by our plan was that at a time in its history this was the only thing that could be done, and we thought it was much better than no plan at all.

COMMISSIONER FRANSSON: Have most commercial carriers got indemnity plans or indemnity type contracts, or service type contracts?

DR. MacMILLAN: In fairness, they have both. They have entered the service field in certain areas in which they offer to pay growth lat usually of an association for certain specified groups. They have not offered to the public as large any service [illegible]

COMMISSIONER MOORTHEAD: [illegible] the service type program will only operate properly if it has the full support of the medical profession in the area?

DR. MacMILLAN: It must not only have the full support; it must have technical [illegible] of performing a service even if in the technical [illegible] there may be no money to pay for it. It is [illegible] already given are guaranteed by the physician without pay.

COMMISSIONER McCUTCHEON: In other words, instead of the user of the service being a co-insurer, the medical profession becomes a co-insurer?

DR. MacMILLAN: That is right.

COMMISSIONER FIRESTONE: I take it that this cooperation is available from the medical profession in Prince Edward Island?

DR. MacMILLAN: Yes, sir.

COMMISSIONER FIRESTONE: Would you say that other insurance companies and other insurance carriers in Prince Edward Island are now offering contracts on a service basis or are they on a limited basis?

DR. MacMILLAN: In Prince Edward Island we do not find any change because most of the coverages that we have here are national groups. There are other package types, salary indemnity and other types of things which influence, but in Prince Edward Island we haven't felt that.

COMMISSIONER FIRESTONE: And so notwithstanding their willingness to cooperate, there has been no change from the service type of contract to the indemnity type of contract?

DR. MacMILLAN: No.

COMMISSIONER FIRESTONE: Is there a change in prospect that you know of?

DR. MacMILLAN: I think the whole field of pre-payment is definitely tending towards more comprehensive contracts, universally available and more service contracts.

COMMISSIONER FIRESTONE: May I turn to page

COMMISSIONER MCCUTCHEON: In other words, as of the year of the service being a continuous [illegible]

[illegible]

in Prince Edward Island?

DR. MACMILLAN: Yes, sir.

COMMISSIONER MCCUTCHEON: Would you say that other insurance companies and other insurance carriers in Prince Edward Island are now offering contracts on a service basis or are they on a limited basis?

DR. MACMILLAN: In Prince Edward Island we do not find any change because most of the contracts that we have here are national groups. There are other package plans, salary takeover, and other forms of things which influence, but in Prince Edward Island [illegible]

COMMISSIONER MCCUTCHEON: [illegible] discussing their willingness to cooperate, there has been no change from the service type of contract to the indemnity type of contract?

DR. MACMILLAN: No.

[illegible]

I suppose that you know off

DR. MACMILLAN: I think the [illegible] development in [illegible] [illegible] comprehensive contracts, [illegible] more service contracts.

COMMISSIONER MCCUTCHEON: May I [illegible]

9, paragraph 29, sub-paragraph 6. You say that no health service should be denied to anyone because of his inability to finance. That, I presume, sir, ties back to your earlier statement of principle that all people in the province of Prince Edward Island should be covered by a health plan?

DR. COADY: Should have it made available to them, yes.

COMMISSIONER FIRESTONE: Then you conclude that in no instance should the coercive power of the state be used to impose either services or economic systems unless all other mechanisms and approaches fail. Could you explain what this paragraph means?

DR. MacMILLAN: I will have to explain that one, too, sir. What we mean in that is just as I finished my answer to the last question, and that is it is an evolutionary progress which is tending towards greater universality, coverage, better comprehensive benefits and service programs. I feel that they have not been given the chance, because they are being critcized because they are unable to cover those who cannot afford to pay. If other mechanisms are set up for those people who cannot pay, the universality of coverage has already been made available without imposing on those people who can pay. In other words, we don't think that looking after the people unable to pay will be attained by putting the voluntary plans out of business.

COMMISSIONER FIRESTONE: Would you say that you would be in favour of many plans to be in operation

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COMMISSIONER RINGSTONE: Then you conclude that in no instance should the coercive power of the state be used to impose either services or economic systems unless all other mechanisms and approaches fail. Could you explain what this paragraph means?

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COMMISSIONER RINGSTONE: Would you say that you would be in favour of many plans to be in operation -

and having separate plans for those that can afford it and for those that cannot afford to pay the premium, or would you say that one province-wide plan might be the more efficient manner in providing health services for the people of Prince Edward Island?

DR. MacMILLAN: Prince Edward Island, which is a group which consists of 600,000, this would make an ideal unit for one plan. If you got up to five million it might be possible that you would set up separate mechanisms. But I think the principle that all the people should be covered by a voluntary mechanism in which those who cannot afford to pay for the service elsewhere are covered is satisfactory. This voluntary mechanism might be three or four separate units.

COMMISSIONER FIRESTONE: If you had four or five plans in operation, do you think that would involve increased costs, because if it was one plan on a larger scale presumably you could administer it economically.

DR. MacMILLAN: It would be our feeling that the value of the competitive elements of three or four components would more than offset any increase in costs, whereas if you had one big one, then you have nothing to control the costs.

COMMISSIONER FIRESTONE: May I pursue this question a little further when you say that competition would provide for increased efficiency of the plans. Now, if we just -- maybe I didn't understand you correctly. Perhaps I should rephrase

DR. McMILLAN: Prince Edward Island, which is a group which consists of 600,000, this world make [illegible] million it might be possible that you would set up separate mechanisms. But I think the principle that all the people should be covered by a voluntary mechanism in which those who cannot afford to pay for the service elsewhere are covered is satisfactory. This voluntary mechanism might be three or four [illegible].

COMMISSIONER FLEMMING: [illegible] or five place or operation, do you think that would involve increased costs, because if it was one plan on a larger scale presumably you could [illegible] [illegible].

DR. McMILLAN: It would be our feeling that the value of the competitive elements in three or four components would more than offset any increase in costs, whereas if you had one big one, then you have nothing to counterbalance the costs.

[illegible] question a little further when you say that competition would provide for increased efficiency [illegible] and you [illegible]. [illegible] [illegible] [illegible]

this in the form of a question. Would you feel, sir, that competition would increase the efficiency of such plans?

DR. MacMILLAN: I wasn't talking about the efficiency of the services being provided, I was talking about the efficiency of the administration.

COMMISSIONER FIRESTONE: Would you then say that competition would increase the efficiency of the administration of these plans?

DR. MacMILLAN: I would rather think so, because the personnel available for most of these things are in rather short supply, and I think the people who could get into the field and give the best service, as in other fields, would do well. If a commodity is in sufficient demand, like any other commodity it is not a deterrent to good administration to have two or three people selling the same thing even at the same price.

COMMISSIONER FIRESTONE: You were saying that the number of competent people to administer such a plan was limited. What does the benefit of having two or three or four plans if you haven't enough for one plan?

DR. MacMILLAN: I didn't say that. What I said was this, that because of the fact that people who are in this business must compete for high-priced actuaries and all the people involved, then they must be efficient and they must give good administrative service. The medical service is in our control and we guarantee that.

[illegible] a question, [illegible] you [illegible] [illegible] such plans?

DR. MACMILLAN: I wouldn't believe that the efficiency of the services being provided, I [illegible]

COMMISSIONER RUSSELL: Would you then say that competition would increase the efficiency of the administration of these plans?

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DR. MACMILLAN: I didn't say that. What I said was this, that because of the fact that people who are in this business must compete for high-priced services and all the people involved, then they must be efficient and they must give good administrative service. The medical service is in our control and we guarantee that.

COMMISSIONER FIRESTONE: If one had a choice of having three or four plans for hiring these people, if there was a scarcity of these people would you still be in favour of three or four plans even though some of the plans would not have access to these people?

DR. MacMILLAN: I am not in favour of three or four plans. I am in favour of a variety of plans where you have a free choice, and that gives you the basis of the capacity of the people to stay in business.

COMMISSIONER FIRESTONE: You would still want administrative costs kept at the lowest possible per capita figure for the people of Prince Edward Island, and the system to be chosen would be the one which would ensure the lowest possible per capita expense?

DR. MacMILLAN: That is right.

THE CHAIRMAN: We will adjourn until 2:00 o'clock.

---The Commission adjourned until 2:00 p.m.

COMMISSIONER FIRESTONE: If one had a choice of having three or four plans for taxing these people, if there was a majority of these people would you still be in favour of three or four plans even though some of the plans would not have access to these people?

DR. MACMILLAN: I am not in favour of three or four plans. I am in favour of a variety of plans where you have a free choice, and that gives you the basis of the capacity of the people to stay in business.

administrative costs kept at the lowest possible per capita figure for the people of Prince Edward Island, and the system to be chosen would be the one which would ensure the lowest possible per capita.

DR. MACMILLAN: That is right.

THE CHAIRMAN: We will adjourn until 2:00

---The Commission adjourned until 2:00 p.m.

--- On resuming at 2:00 p.m.

COMMISSIONER FIRESTONE: Mr. Chairman, if I may continue with my questioning of Dr. Coady. Paragraph 31 on page 9, you speak of certain basic services which you feel should be provided, and in certain additional services, and under sub-paragraph 1 you speak of those additional benefits which are necessary to recovery, and you include extra nursing services for the seriously ill, and drugs medically necessary irrespective of cost , and C of para-medical service necessary for diagnosis and treatment of disease, including laboratory facilities. Now, sir, in paragraph 79(b) you say that these additional services might be provided in a supplementary plan, or, as you call it, an extended benefit contract. Am I to understand, sir, that these special services are not to be included in a basic contract?

DR. COADY: Mr. Chairman, no, it was our intention that the para-medical services would have to be included in the basic contract. The para-medical services which are mentioned here, laboratory facilities, such as x-ray and physiotherapy are services which under our present plan are covered under our hospitalization scheme, and therefore it would not be necessary for them to be covered under any proposed medical scheme.

COMMISSIONER FIRESTONE: Would the extra nursing services for the seriously ill be included in your basic plan?

COMMISSIONER FIRESTONE: Mr. Chairman, if I

Paragraph 31 on page 9, you speak of certain basic services which you feel should be provided, and in

I you speak of those additional benefits which are necessary to recovery, and you include extra nursing services for the seriously ill, and drugs medically necessary irrespective of cost , and d of paramedical service necessary for diagnosis and treatment of disease, including laboratory facilities. Now, sir, in paragraph 72(b) you say that these additional services might be provided in a supplementary plan, or, as you call it, as extended benefit coverage. Am I to understand, sir, that these special services are not to be included in a basic contract?

DR. COLDEY: Mr. Chairman, no, it was our intention that the para-medical services would be to be included in the basic contract. The para-medical services which are mentioned here, ambulance facilities, such as x-ray and physiotherapy are services which under our present plan are covered under the hospitalization scheme, and therefore it would not be necessary for them to be covered under any para-medical scheme.

COMMISSIONER FIRESTONE: Would the extra nursing services for the seriously ill be i[illegible]

DR. COADY: It is also covered under our hospital scheme at the present time.

COMMISSIONER FIRESTONE: If you recall, we are discussing a basic plan which your Association has recommended. Are these nursing services included in such a plan?

DR. COADY: No, they wouldn't be sir. They are included in our hospitalization scheme, if you refer to necessary in-hospital nursing.

COMMISSIONER FIRESTONE: What does 1A in paragraph 31 refer to: "Extra nursing services for the seriously ill"? Does that cover in-hospital, or out of hospital nursing services?

DR. COADY: That refers to in-hospital extra nursing service. We assume that any patient who is seriously ill will be treated in hospital.

THE CHAIRMAN: Is that not now covered by the hospitalization scheme?

DR. COADY: Yes sir, that is right.

COMMISSIONER McCUTCHEON: Before we leave paragraph 31, you have a section 2: "Benefits having no relation to disease or recovery but related to patient's economic well-being." Would you not consider that in many circumstances income protection might contribute to a patient's recovery?

DR. COADY: Well, it is conceivable, sir, I think we would have to admit under certain circumstances, and in certain illnesses, and in certain individuals, conceivably we would have to admit that they might, in an indirect manner.

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DR. COADY: It is also covered under our hospital scheme at the present time.

COMMISSIONER FIRESTONE: If you recall, we are discussing a basic plan which your Association has recommended. Are these nursing services included in such a plan?

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DR. COADY: That refers to in-hospital extra nursing service. We assume that any patient who is seriously ill will be treated in hospital.

THE CHAIRMAN: Is that not now covered by the hospitalization scheme?

COMMISSIONER McCUTCHEON: Before we leave paragraph 31, you have a section 2: "Benefits having no relation to disease or recovery but relation to patient's economic well-being." Would you not consider that in many circumstances income protection might contribute to a patient's recovery?

DR. COADY: I think we would have to admit under certain circumstances and in certain illnesses, and in certain individuals, conceivably we would have to admit that they might

COMMISSIONER McCUTCHEON: I will put it this way. If, as one of your colleagues suggested, that the definition of disease was lack of ease, would you agree that absence of the benefits listed in paragraph 2,A,B and C might result in disease?

DR. MALONEY: Well, it may be within the definition of disease. This does not necessarily mean that everything should be covered by insurance. We think perhaps this would be perhaps a good place for the economist to take over and cover income loss. We do not have the medical service to cover ultimately everything related to the life of man on earth. We do not feel we can carry on this whole field ourselves.

DR. MacMILLAN: May I add one word to that. Our definition of medical service in the wide sense includes all of those things ordered by a doctor and either carried out by himself or by some para medical worker. Doctors do not order income protection.

COMMISSIONER FIRESTONE: If I may return, Dr. Coady, to my question about the nursing services and draw your attention to what you are saying on page 23, paragraph 79B continued. You say in this paragraph that para medical services including drugs, appliances, nursing, should be included in what you call an extended benefit contract sold as a supplementary by the carrier. Does that mean that you are in favour of providing a service scheme which would include nursing services for those that are ill or seriously ill outside of hospital?

DR. MacMILLAN: Would you repeat that?

the definition of disease was lack of ease, would you agree that absence of the benefits listed in paragraph

DR. MALONEY: Well, it may be within the definition of disease. This does not necessarily mean that everything would be covered by insurance. We think perhaps this would be perhaps a good place for the economist to take over and cover insure loss. We do not have the medical service to cover literally everything related to the life of man on earth. We do not feel we can carry on this whole field ourselves.

DR. MACMILLAN: May I add one word to that. Our definition of medical service in the white paper includes all of those things covered by a doctor not either carried out by himself or by some paramedical worker. Doctors do not under insure provincially.

Dr. Cody, to my question about the nursing services and drew your attention to what you are asking on page 23, paragraph 72B continued. You say in this paragraph that para medical services including drugs, appliances, nursing, should be included in what you call an extended benefit contract and as a supplement by the carrier. Does that mean that you are in favour of providing a service scheme which would include nursing services for those that are ill in institutions ill outside of hospitals?

DR. MACMILLAN: Would you repeat that?

COMMISSIONER FIRESTONE: Paragraph 79B, on page 23, in which you say that: "Para-medical services including drugs, appliances, nursing, etc... could be included in an extended benefit contract sold as supplementary by the carrier." Does it mean that you are in favour of nursing services to be included in a comprehensive medical care program in the province of Prince Edward Island?

DR. MacMILLAN: Well, as you notice here, the intent of this area, as compared to the one you had been quoting before, they are repeated, but with different connotations. What we are trying to establish in this particular paragraph mainly is that the cost of those services provided mainly by doctors should not be adversely or favourably affected by the cost of other para-medical services. Whether or not you can put them in a basic is a question. You see, the difference between the basic contract and the basic plus extended benefits is, in our way of thinking different from others. There are some who think that other medical services should be included, maybe specialist services in the basic and physicians in the basic, or special service in the supplementary and so forth, but we are thinking that with the basic, we use nursing in the sense of this paragraph as different from the other auxiliary nursing as we spoke of this morning, nursing in this sense here is in that particular instance, it is not connected with the hospital plan. Anytime we speak of nursing in connection with the hospital plan, that

[illegible]

[illegible] 23, in which you say that: "Para-medical [illegible] as supplementary by the counties." Does it mean that you are in favour of nursing services to be included in a comprehensive medical care program in the province of Prince Edward Island?

Dr. MacMILLAN: Well, as you notice here, the intent of this area, as compared to the one you had been reading before, they are separated, but with different conditions. What we are trying to establish in this particular paragraph mainly is that the cost of these services provided mainly by counties should not be assessed or favourably affected by the cost of other para-medical services. Whether or not you can put them in a basic is a question. In one, the difference between the basic services and the basic plans existed therefore is, in our way of thinking different from others. There are some who think that other medical services should be included, maybe specialist services in the basic, or physiotherapy in the basic, or special service in the supplementary and so forth, but we are thinking that with the basic, we use nursing in the sense of this paragraph as different from the other auxiliary nursing as we spoke of this morning, nursing in this sense here is in that particular instance, it is not connected with the hospital plan. Anytime we speak nursing in connection with the hospital plan, that

is completely covered, so we are only talking about what is not completely covered.

COMMISSIONER FIRESTONE: Do I understand that the doctors are in favour only of a medical care program covering medical services or are the physicians of Prince Edward Island in favour of a medical care program covering all medical services, which would include nurses, specialists, etc.?

DR. COADY: I believe we have stated that we are in favour of a medical care program which includes medical services. We are also in favour of a medical care program which provides para-medical services, and we are recommending that these two programs be kept separate, that one be sold as the basic contract, and the second as a supplementary contract, and the funds administered separately.

COMMISSIONER FIRESTONE: That is a clear statement, and thank you very much for the answer. On the question of drugs, it has been suggested to the Commission that if there were a medical care plan which includes the provision of drugs, that such a plan might be misused by (a) doctors being too liberal in the prescription of drugs; and (b) by patients demanding drugs in many cases where such drugs would not be justified. Would you be afraid of this happening if there were a medical care plan in the Province of Prince Edward Island which provides for coverage on drugs?

DR. COADY: I could only give my personal opinion on that, sir, and personally I would have some

is completely covered, so we are only talking about what is not completely covered.

COMMISSIONER FIRESTONE: Do I understand that the doctors are in favour only of a medical care program covering medical services or are the physicians of Prince Edward Island in favour of a medical care program covering all medical services, which would include nurses, specialists, etc.?

DR. GOADY: I believe we have stated that [illegible] includes medical services. We are also in favour of a medical care program which provides non-medical services, and we are recommending that these two programs be kept separate, that one be said a the basic contract, and the second as a supplementary contract, and the first administered separately.

[illegible]

On the question of cost, it has been suggested to the Commission that if there were a medical care plan which included the provision of drugs, that such a plan might be manned by (a) doctors being too liberal in the prescription of drugs; and (b) by patients demanding drugs in many cases where such drugs would not be justified. Would you be afraid of this happening if there were a medical care plan in the province of Prince Edward Island which provides for coverage on drugs?

DR. GOADY: I could only give my personal opinion on that, sir, and personally I would have each

apprehension that this might happen, and I think it has happened in places where such a policy has been established.

COMMISSIONER FIRESTONE: Would it be possible perhaps to address the question to some of your colleagues, to find out whether they share the view the doctors would prescribe for drugs even though drugs are not required, because this would be a too liberal use of the drug provisions ?

DR. MALONEY: I think, sir, that it is like many things in life, you cannot answer 100 per cent yes or no. I would say 99.9 per cent this would not be the case, but it may be the case in isolated or individual cases, but I think it would be conspicuous by its insignificance. The other thing is, of course, it is incumbent on anybody dispensing medical service that he strive ever to reduce the problem, to reduce the over-utilization of this thing in which the responsibility belongs both to the doctor and to the patient, and demands education on both parts, and we are quite willing to accept that.

COMMISSIONER STRACHAN: Paragraph 79B continued, I notice that you have included dental services in para-medical services. I would like to know if the physicians who are members of your Association have entered into any deliberations with the dental association of this province in placing the dental services in that category?

DR. COADY: No sir, I don't believe we have

apprehension that [illegible] has happened [illegible]

perhaps to address the question to some of your colleagues, to find out whether they share the view the doctors would prescribe for drugs even though drugs are not required, because this would be a too liberal use of the drug provisions.

DR. MALOWAY: I think, sir, that it is true many things in life, you cannot answer 100 per cent yes or no. I would say 99.9 per cent this would not be the case, but it may be one in hundred or individual cases, but I think it would be conscientious by the transgressions. [illegible] is, of course, it is incumbent on everyone [illegible] medical service that he strive ever to resolve the problem, to reduce the over-utilization of this thing in which the responsibility belongs both to the doctor and to the patient, and research [illegible] on both parts, and we are quite willing to accept

continued. I notice that you have included dental services in para-medical services. I would like to know if the physicians who are members of your Association have entered into any discussion with the dental association of this province in providing the dental services in that category?

DR. COOK: No sir, I don't believe we have

had any meetings on that.

COMMISSIONER FIRESTONE: May I come back to Dr. Maloney's remarks about the prescription of drugs. I take it, Dr. Maloney, from what you say, that if 99.9 per cent of the physicians can be relied upon to use their good judgment and not prescribe drugs that are not required, that the danger of over-utilization is very minimum, and therefore such a scheme should not be considered as being impossible for implementation because of that too liberal prescription fear that has been expressed?

DR. MALONEY: Yes, I wouldn't like to be tied down to this exact percentage. I mean the great, great majority. I think that what you have said is correct, and that is the medical profession should be prepared in the event of such a scheme to discipline itself.

COMMISSIONER FIRESTONE: I am rather encouraged by what you say, and I accept your answer in that spirit. Thank you. May I now turn to paragraph 34 on page 11. Dr. Coady, you name in this paragraph several groups of the population which will require assistance to enable them to provide themselves with prepaid medical care insurance, and you include in No. 1 the persons of any age with low income and limited financial means, and persons uninsurable because of pre-existing disease, a person 65 years of age and older. How would those persons be determined? Are you and your Association recommending a means test?

my meetings on that.

I take it, Dr. Maloney, from what you say, that 99.9 per cent of the physicians can be relied upon to use their good judgment and not prescribe drugs that are not required, that the danger of over-utilization is very minimum, and therefore such a scheme should not be considered as being impossible for implementation because of that too liberal presumption that has been expressed.

DR. MALONEY: Yes, I would like to be tied down to this exact percentage. I mean the great great majority. I think that what you have said is correct, and that is the medical profession should be prepared in the event of such a scheme to discipline itself.

COMMISSIONER WINSTONE: I am rather encouraged by what you say, and I accept your answer in that spirit. Thank you. May I now turn to paragraph 24 on page 11. Dr. Coady, you mean in this paragraph several groups of the population that will require assistance to enable them to provide themselves with prepaid medical care insurance. Are you included Mr. ? the persons of any age with low income and limited financial means, and persons uninsurable because of pre-existing diseases, a person 65 years of age and older. How would those persons be determined? Are you sure your association recommending a means test?

DR. COADY: Yes, oh yes. We don't believe, sir, that they could be determined in any other manner.

COMMISSIONER FIRESTONE: Do you think people like being subjected to a means test?

DR. MALONEY: I would answer no. There are many conditions under which people do not like being subjected to a means test. I think the commonest one is the income tax, but we live with this, we are divided in many ways by incomes all through life. We don't think there is anything sacrilegious about a means test at all.

COMMISSIONER FIRESTONE: Thank you. Page 13, paragraph 42. Would you recommend, sir, that a prepaid medical plan would cover also medical services for the mentally ill.

DR. COADY: Yes, we recommend that, sir.

COMMISSIONER FIRESTONE: Paragraph 84, on page 24. You make a case that the scheduled fees should remain fair and equitable, and maintain the same relationship to the cost of living index that it now bears. This is a very sensible and reasonable request. I would like to draw your attention in this connection to paragraph 14, contained in appendix B of the Canadian Medical Association's statement on medical services insurance, which I understand your Association has endorsed, where you speak of provisions being made for periodic or automatic changes in remuneration to reflect changes in economic conditions. I wonder how you would achieve automatic changes?

DR. COADY: Well, sir, the interpretation of

life being subjected to a means test?

Mr. [illegible]: [illegible] are many conditions under which people do not like being subjected to a means test. I think the commonest one is the income tax, but we live with this, we are divided in many ways by incomes all through life. We don't think there is anything exceptional about a means test at all.

[illegible]

13, paragraph 42. Would you recommend, sir, that a prepaid medical plan would cover also medicine, services for the mentally ill.

Mr. [illegible]: Yes, we recommend that, sir.

COMMISSIONER MINSTONE: Paragraph 44, page 24. You make a case that the advertised fees should remain fair and equitable, and maintain the same relationship to the cost of living index that it now bears. This is a very sensitive and reasonable request. I would like to draw your attention in this connection to paragraph 13, contained in appendix B of the Canadian Medical Association's statement on medical services insurance, which I understand your Association has endorsed, where you speak of provision being made for periodic or automatic changes in remuneration to reflect changes in economic conditions. I wonder how you would achieve automatic changes?

that, my interpretation of an automatic change in the remuneration would be one in which your fee schedule would automatically be altered with a change in the cost of living index.

DR. MacMILLAN: I don't think we can answer this categorically, but I think basically it would be contingent upon a contract. In other words, if there were certain conditions applied, then automatically they would follow and that these conditions might have to be established, as Dr. Coady says. I don't say that every month when the cost of living index comes out the fee changes. But the time interval must be within reason. I don't think there is any absolute answer to it, but if it were in the contract that it be automatic, then we say it should be automatic. If it were in a contractual thing, we say there should be arrangements for periodic, there should be negotiations. That is why we say periodic, or automatic, and it would also apply to where a man's status is changed,and he has taken two or three years extra work and is put in a new category. Then his remuneration should be automatic. Those are examples.

COMMISSIONER FIRESTONE: Thank you. Paragraph 86 on page 25. In sub-paragraph 5 your Association expresses the view that no government interference is demanded, implied or possible. Are you visualizing that government would have a say in the administration of a plan of the type which you have recommended, to which government would make a contribution?

in the cost of living index.

DR. MACMILLAN: I don't think we can answer this categorically, but I think basically it would be contingent upon a contract. In other words, if they would follow and that these conditions might have to be established, as Dr. Coady says. I don't say that every month when the cost of living index comes out the fee changes. But the time interval must be within reason. I don't think there is any absolute answer to it, but if it were in the contract that it be automatic, then we say it should be automatic. If it were in a contractual thing, we may have about to arrangements for periodic, there should be negotiations. That is why we say periodic, or automatic, and it would also apply to where a major status is changed, and he has taken two or three years extra work and is put in a new category. Then his remuneration should be automatic. Those are examples.

66 on page 25. In sub-paragraph j your Association expresses the view that no government interference is demanded, implied or possible. Are you virtually that government would have a say in the administration

DR. COADY: They would have a say, sir, I think in our intention of that I think they would have some say, yes.

COMMISSIONER FIRESTONE: What form would that say take?

DR. MacMILLAN: You have to distinguish there. If the government is paying the total premium for one group of citizens, such as those who are considered unable to pay, the say that they would have in this part of the program would be considerably different than that of the program in which the people pay out of their own pockets.

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[illegible] in our inspection of that I think they would [illegible]

COMMISSIONER FIRESTONE: What form would that say take?

DR. MacMILLAN: You have to distinguish there. If the government is paying the total premium for one group of citizens, such as those who are considered unable to pay, the way that they would have in this part of the program would be considerably different than that of the program in which the people pay out of their own pockets.

I think it would be fair to say if government is paying the whole thing, then any negotiations will be heavily loaded with government responsibility. On the other hand, a change of government or a change of politics would not influence these particular contracts, and this is what we mean by that.

COMMISSIONER FIRESTONE: Just trying to understand what you are saying -- to get a definition: would you feel if government participates in the administration of such a scheme that they would have a say on the kind of services that doctors provide, or would that be confined only to the kind of services provided to the medical indigent, or would the same standard apply to all people?

DR. MacMILLAN: There is only one judge of the standard of medical services, and it is the medical profession.

THE CHAIRMAN: Patients have no say?

DR. MacMILLAN: They have a choice.

THE CHAIRMAN: They have a choice of physician, but you say they have no say in the standard of service?

DR. MacMILLAN: They would not be able to judge what good services -- they may have an opinion, of course, but I don't think they would have any ability to change that standard or determine what standard should be given. I don't think, for example, that the public would have any ability to say who might or might not be allowed to do certain types of surgery in hospital. This is what I mean. I don't

paying the whole thing, then any negotiations will be

the other hand, a change of government or a change

contracts, and this is what we mean by that.

COMMISSIONER FIRESTONE: Just trying to understand what you are saying -- to get a definition:

administration of such a scheme that they would have a say on the kind of services that doctors provide, or would that be confined only to the kind of services provided to the medical indigent, or would the same standard apply to all people?

DR. MACMILLAN: There is only one level of the standard of medical services, and it is the optimal

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think any hospital board would say who could do surgery in hospital.

THE CHAIRMAN: Is there any other class that is also infallible?

DR. MacMILLAN: I didn't say that, sir. But, I think medical competence has to be judged by professional self judgment.

COMMISSIONER FIRESTONE: To pursue this question a little further on the administration aspect, you have said, if I understood you correctly, that you would expect government participation in the administration of such a scheme, assuming government contributes to the cost of such a scheme according to your proposal covering those costs affecting the medically indigent; is that correct?

DR. MacMILLAN: Yes, sir.

COMMISSIONER FIRESTONE: Now, if government did participate in the administration of such a scheme, would you consider that government interference in accordance with sub-paragraph 5 of paragraph 86?

DR. MacMILLAN: No, that would be government cooperation.

COMMISSIONER FIRESTONE: In other words, you are in favour of a scheme that would be developed by the profession -- call them cooperative agencies -- and the government?

DR. MacMILLAN: Yes, sir.

COMMISSIONER FIRESTONE: I would like to come now to paragraph 86, sub-paragraph 9. You state there that controls would be desirable by government,

--that are hospital board would say who could do --surgery in hospital.

THE CHAIRMAN: Is there any other clause that ---------

I think medical competence has to be judged by ---------

COMMISSIONER FIRSTONE: To pursue this question a little further on the administration aspect, you have said, if I understood you correctly, that you would expect government participation in the administration of such a scheme, assuming government contributes to the cost of such a scheme according to your proposal covering those costs affecting the medically indigent; is that correct?

DR. MACMILLAN: Yes, sir.

COMMISSIONER FIRSTONE: Now, if government did participate in the administration of such a scheme, would you consider that government interference in accordance with sub-paragraph 3 of paragraph 86?

DR. MACMILLAN: No, that would be government ---------

COMMISSIONER FIRSTONE: In other words, you are in favour of a scheme that would be developed by the profession -- call them cooperative societies - and the government?

DR. MACMILLAN: Yes, sir.

COMMISSIONER FIRSTONE: I would like to come now to paragraph 86, sub-paragraph 9. You state

the profession and the carrier, to prevent over-utilization, excessive servicing and to keep the costs at correct levels. Do you have anything specific in mind to prevent over-utilization?

DR. MALONEY: To give you an example of how it would operate, we do this in the Hospital Services Commission in each of the hospitals right now. We have a standards committee, and this reviews patients who come into hospital and question (a) whether or not they should be admitted, and (b) whether or not they are staying too long and (c) whether or not they should be discharged. If we find such is the case we immediately get after the person who has been there and see that the proper thing is done. In this way we have been able to keep our hospitalization stay down to a very reasonable level, and we think we have cut out over-utilization to a great extent. We are thinking of exactly the same method of dealing with over-utilization in medical services, that if there appears to be over-utilization in certain areas, then the records would be reviewed, committees set up to go out to the area and ask why this area seems to have four times as much pneumonia as any other county.

COMMISSIONER FIRESTONE: In other words, you are visualizing some control exercised by a committee or sub-committee appointed by the agency which will be administering the scheme, and presumably some members of the medical profession would be members of the committee?

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COMMISSIONER WINSTONE: In other words, you are visualizing some central supervision by a committee or sub-committee appointed by the agency which will be administering the scheme, and presumably some members of the medical profession would be members of the committee?

DR. MALONEY: Yes, sir.

COMMISSIONER FIRESTONE: You also speak of excessive servicing: would the same principle apply on excessive servicing as over-utilization?

DR. MALONEY: Exactly the same principle, sir.

COMMISSIONER FIRESTONE: You also speak of keeping costs at correct levels: how do you determine a correct level?

DR. MALONEY: We don't know the answer to that question.

DR. MacMILLAN: There is such a thing as a pattern of practice, and if you take the claims of fifty doctors doing internal medicine, for example, you develop what is known as a pattern practice for each person. There are certain ways and means of determining deviates from the pattern of practice, and if they go beyond certain levels you make individual investigations,much the same way as tissue committees control surgery within the hospital. It is a very real way that has been developed by the prepaid plans now and accepted by the profession in many ways. There are many types of analyses being done, particularly on in-hospital care where you examine the professional servicing in the hospital to determine whether they conform with certain patterns, and this is something that is being developed, and I am quite sure we could do it.

COMMISSIONER FIRESTONE: Mr. Chairman, I am coming to my last question and it deals again with

DR. MALONEY: Yes, sir.

COMMISSIONER FIRSTONE: You also speak of [illegible] on excessive servicing as over-utilization?

DR. MALONEY: Exactly the same principle.

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DR. MACMILLAN: There is such a thing as a pattern of practice, and if you take the claims of [illegible] you develop what is known as a pattern practice for each person. There are certain [illegible] and means of determining deviates from the pattern of practice, and if they go beyond certain levels you [illegible] individual investigations, much the same way as [illegible] is a very real way that has been developed by the prepaid plans now and accepted by the profession in many ways. There are many types of services being done, particularly on in-hospital care where you [illegible] the professional servicing in the hospital to determine whether they conform with certain patterns, and this is something that is being developed, and I am quite sure we could do it.

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coming to my last question and it deals again with

principle. It is No. 5 of the statement on medical services insurance contained in appendix B which is the statement of the Canadian Medical Association which I understand the Medical Society of Prince Edward Island has endorsed, and in this No. 5 you say that while there are certain areas of medical services in which tax supported programs are necessary, a tax supported comprehensive program, compulsory for all, is neither necessary nor desirable. I take it, sir, having reproduced the full text of the statement that your own Association endorses this principle, or do you wish to elaborate on it?

DR. COADY: We endorse this principle, sir.

COMMISSIONER FIRESTONE: May I ask you some questions -- and what I am after is your genuine views expressed in your own words. We are familiar with the principle which has been presented to us by the Canadian Medical Association, but we are interested to know as to what the medical profession in Prince Edward Island thinks about this principle. You say that a tax supported comprehensive program is neither necessary nor desirable: are you or are you not in favour of a comprehensive program?

DR. COADY: Yes, we are in favour. We would hope any proposed program would be comprehensive. We would not be in favour, however, of passing a law which would make it compulsory for all citizens to have to participate in such a program.

COMMISSIONER FIRESTONE: I would like to come back to this compulsory feature in a minute, and

principle. [illegible]

services insurance contained in appendix B which is [illegible]

understand the Medical Society of Prince Edward Island has endorsed, and in this No. 5 you say that while there are certain areas of medical services in which tax supported programs are necessary, a tax supported comprehensive program, compulsory for all, is neither necessary nor desirable. I take it, you, having reproduced the full text of the resolution that your own Association endorses this principle, or do you wish to elaborate on it?

DR. COADY: We endorse this principle, sir.

COMMISSIONER RIDDELL: May I ask you some questions -- and what I am after is your genuine views expressed in your own words. We are familiar with the principle which has been promulgated to us by the Canadian Medical Association, but we are interested to know as to what the medical profession in Prince Edward Island thinks about this principle. You say that a tax supported comprehensive program is neither necessary nor desirable; are you or are you not in favour of a comprehensive program?

DR. COADY: Yes, we are in favour. We would hope any proposed program would be comprehensive. We would not be in favour, however, of passing a law which would make it compulsory for all citizens to become participants in such a program.

COMMISSIONER RIDDELL: I would like to come back to this compulsory feature in a minute, and

just proceed to the questioning stage to be helpful to you: you are, therefore, in favour of a comprehensive program?

DR. COADY: Yes, sir, that is right.

COMMISSIONER FIRESTONE: Are you in favour of a tax supported comprehensive program? As I understood earlier, you visualized that the state would pay one way or the other some of the costs required to pay for some people: I presume that the state will obtain some of these funds from the taxes it collects. Are you, therefore, in favour of a tax supported comprehensive program?

DR. COADY: We are in favour, as I believe we have stated, of a program which is voluntary and in which self-supporting citizens pay their own premiums and in which those citizens who are unable to do so would have assistance from government.

COMMISSIONER FIRESTONE: I take it that if government pays the cost of what you might describe as a medical indigent, and assuming this money to pay for these costs comes from taxes, wouldn't that be a tax supported comprehensive program?

DR. COADY: I would say it would be a partially tax supported comprehensive program.

COMMISSIONER FIRESTONE: So you are in favour of a partially tax supported comprehensive program?

DR. COADY: Yes, sir.

DR. MacMILLAN: May I say, Mr. Chairman, you can't break this sentence up in this way, piecemeal and get the intent of it. This is not correct. The

COMMISSIONER FIRESTONE: Are you in favour of

understood earlier, you visualized that the state would pay one way or the other some of the costs required to pay for some people: I presume that the state will obtain some of these funds from the person it collects. Are you, therefore, in favour of a tax supported comprehensive program?

DR. COADY: We are in favour, as I believe we have stated, of a program which is voluntary and in which self-supporting citizens pay their own premiums and in which those citizens who are unable to do so would have assistance from government.

COMMISSIONER FIRESTONE: I take it that if government pays the cost of what you might describe as a medical indigent, and assuming this money to pay for these costs comes from taxes, wouldn't this be a tax supported comprehensive program?

DR. COADY: I would say it would be a partial tax supported comprehensive program.

COMMISSIONER FIRESTONE: So you are in favour of a partial, tax supported comprehensive program?

[illegible]

You can't break this sentence up in this way, pieceme[illegible] and get the intent of it. This is not correct. The

"tax supported" is not modifying "comprehensive", but it is modifying "comprehensive program compulsory for all", and I think the intent of saying "tax supported" as regards "comprehensive benefits" does not apply.

COMMISSIONER FIRESTONE: Thank you for your help, Dr. MacMillan. I would like to come to this word "compulsory". The reason I am proceeding stage by stage is to make it more helpful rather than asking a question that covers five questions at once. If I may turn to the word "compulsory", can you explain to the Commission why the Medical Society of Prince Edward Island is not in favour of a compulsory scheme covering all citizens in Prince Edward Island?

DR. MALONEY: Well, it goes further than medicine, sir. We subscribe to what I think has been called the principle of subsidiarity", and that is, that you should not do on a higher level what can be done on a lower level. We don't believe government should do for people what people can do for themselves, and that is the basic tenet on which we make that statement.

COMMISSIONER FIRESTONE: This question is addressed either to Dr. Coady or Dr. Maloney: are you satisfied with the hospital insurance scheme as it is in operation at the moment?

DR. COADY: Yes, we are satisfied with the operation.

COMMISSIONER FIRESTONE: Is this a compulsory scheme or not?

supported" as regards "comprehensive benefits" does not apply.

COMMISSIONER [illegible]: Thank you for your help, Dr. McMillan. I would like to come to this word "compulsory". The reason I am proceeding step by stage is to make it more helpful rather than asking a question that covers two questions at once. If I may turn to the word "compulsory", can you explain to the Commission why the Medical Society of Prince Edward Island is not in favour of a compulsory scheme covering all citizens in Prince Edward Island?

[illegible] medicine, sir. We subscribe to an old [illegible] has been called the principle of subsidiarity", and we say to that you should not do on a higher level what can be done on a lower level. We don't believe government should do for people what people can do for themselves, and that is the basic tenet on which we make that statement.

[illegible] addressed either to Dr. Conroy or Dr. Maloney: Are you satisfied with the hospital insurance scheme as it is in operation at the moment?

DR. CONROY: Yes, we are satisfied with the operation.

COMMISSIONER FORRESTER: In this a compulsory scheme or not?

DR. COADY: No, it is not compulsory in this province.

COMMISSIONER FIRESTONE: Who subscribes in this province? Who are the people who participate in the hospital insurance scheme?

DR. COADY: Anybody who wishes to, sir.

COMMISSIONER FIRESTONE: I would like to come back to this "compulsory" again, and I am trying to understand what you have in mind. I am referring to your paragraph 81 on financing. Your recommendation in paragraph 81, sub-paragraph 1 is that all persons of the community are pooled as a single group risk, and you recommend that a community rate is struck for the total population; is that correct?

DR. COADY: Yes, sir.

COMMISSIONER FIRESTONE: Let us assume a community rate is struck and it is based on everyone participating in such a scheme, because otherwise you would have people, say, between twenty and fifty whose rate would be much lower, and if you had a scheme where you allow people to join or not to join and you struck a community rate, the community rate is an average rate. Now, let us assume that the healthy group -- the relatively healthy group between twenty and fifty decided to co-opt out: how would the community rate work?

DR. COADY: Was your statement that we assume that the group between twenty and fifty -- did not what?

COMMISSIONER FIRESTONE: May I start again

and just try and be helpful to you. You have suggested in paragraph 81 that all persons of the community should pool their risks and you would strike an average rate. That is a very fair proposal, and everyone in Prince Edward Island is part of a pool of risks, and by pooling the risks, you get the lowest possible average rate.

DR. COADY: Yes.

COMMISSIONER FIRESTONE: All right. Now, if you have a voluntary scheme and no compulsion, and if you leave it to certain groups to co-opt out, what is to prevent those in the healthier age groups going to an insurance company and saying, "Look, I am between twenty-five and thirty-five -- a very healthy speciman; my incidence of ill health is very small. Can you give me insurance at the lower rate?" Don't you think that other carrier could provide for this special group a rate that would be lower than the average of the community, and therefore once you had a system where people can co-opt out because they are in a reduced or preferred category, would you leave the rest of the community bearing a much higher burden; is that what you are for?

DR. COADY: No, sir. I believe our proposal was that any contract which is made available to any preferred group would have to be made available to all the citizens of the island, and I think this set-up would have to be, largely through the Department of Insurance or through some mechanism, would have to be, largely, that a contract made

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[illegible]

[illegible] in paragraph 81 that all persons of [illegible] rate. That is a very fine proposal, and everyone in Prince Edward Island is part of a [illegible] of risks, and by pooling the risks, you get the [illegible]

DR. COADY: Yes.

COMMISSIONER FIRMINGER: And [illegible] you have a voluntary scheme [illegible] and if you leave it to certain groups [illegible] to prevent those in the healthier age groups [illegible] to an insurance company and saying, [illegible]

[illegible] insurance of [illegible] health to [illegible] have the insurance at the lower rate [illegible] think that other carriers could pick up the [illegible] another group a rate that would be lower than the average of the community, can therefore give [illegible] a certain number people can come [illegible] that are in a reduced or preferred category, [illegible] leave the rest of the community bearing a much [illegible] burden, is that what you are for?

DR. COADY: Yes, sir. I believe our position was that any [illegible] which is made available to any preferred group would have to be made available to all the citizens of the Island, and I think this set-up would have to be, largely through the Department of Insurance or through some mechanism, would have to be, largely, that a contract made

available to any group must be made available to all citizens.

COMMISSIONER FIRESTONE: That is a very fair proposal, but let us think the proposal out. This is a voluntary scheme, and you offer it to everybody. The people in the old age groups are very happy to get the low rate, and the whole community shares the risk -- wonderful. Some people -- the younger age group -- say, "Why should I pay the average rate if I can get a lower rate in my own age group?", and then this particular group of people goes to another insurance carrier and says, "Can you give me a lower rate?"

DR. COADY: Excuse me: he can't do it in Prince Edward Island if it is controlled, because if that carrier can provide insurance to that special group at a lower rate, then he, as I understand it, would have to make that same contract available to everybody.

THE CHAIRMAN: Have you satisfied yourself that this person that wants the lower rate that Dr. Firestone has been talking about cannot buy it elsewhere than in Prince Edward Island?

DR. MacMILLAN: He cannot buy ward and hospital insurance.

THE CHAIRMAN: But he can buy a contract anywhere in the world, can't he?

DR. MacMILLAN: No; you can't use it here.

THE CHAIRMAN: Well, I am not going to suggest what the legal implication might be, but my only

lable to any group must be made available to all citizens.

COMMISSIONER PIERSTONE: This is a very fair proposal, but let us think the proposal out. This is a voluntary scheme, and you offer it to everybody. The people in the old age groups are very happy to get the low rate, and the whole community shares the risk -- wonderful. Some people -- the younger age group -- say, "Why should I pay the average rate if I can get a lower rate in my own age group?" and then this particular group of people goes to another insurance carrier and says, "Can you give me a lower rate?"

DR. COADY: Because you do not do it in Prince Edward Island if it is compulsory, because that carrier can provide insurance to that special group at a lower rate, then he, as I understand it, would have to make that same concession available to everybody.

THE CHAIRMAN: Have you substituted yourself for that person that wants the lower rate that Dr. Pierstone has been talking about cannot buy it elsewhere than in Prince Edward Island?

DR. MACMILLAN: He cannot buy ward and

THE CHAIRMAN: But he can buy a contract anywhere in the world, can't he?

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suggestion is that maybe you should consult your solicitor.

DR. MacMILLAN: He may have a policy in the United States which will pay him for hospital insurance, but I am not sure of the legal implications, but I believe it is illegal to sell this in Prince Edward Island under the present Act. I am not sure, but I believe that is so.

COMMISSIONER FIRESTONE: In other words, what you are trying to say is thatyou feel there is no compulsory scheme necessary because you are compelling people only to take out contracts which are approved in the Province of Prince Edward Island?

DR. COADY: We are encouraging them to take out these contracts; not compelling them.

COMMISSIONER FIRESTONE: Yes, but if your proposals were implemented, would you have a scheme which would set certain standards and nobody else could sell a policy below those standards?

DR. COADY: That is right.

COMMISSIONER FIRESTONE: And terms?

DR. COADY: Yes.

COMMISSIONER FIRESTONE: Therefore, you would be compelling people, if they want a policy, to either take the policies which are approved, or there is no policy available in Prince Edward Island; is that correct?

DR. COADY: That is correct. They have to buy what is available or not buy at all.

COMMISSIONER FIRESTONE: In other words, you

suggestion is that maybe you should commit some [illegible]

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DR. COADY: That is correct. They have to buy what is available or not buy at all.

COMMISSIONER FIRESTONE: In other words, you

would make it impossible for certain groups that are in the lower risk category to take advantage of taking out other contracts and letting the rest of the community carry the higher costs for the rest of the citizens of Prince Edward Island; is that the objective?

DR. COADY: We are proposing that any contract made available to any group of citizens of Prince Edward Island must be made available to all.

COMMISSIONER FIRESTONE: Having said that, sir, does it mean that people are free to go somewhere else to get better contracts?

DR. COADY: Outside of the province?

COMMISSIONER FIRESTONE: Yes.

DR. COADY: Well, I would think that there would have to be a mechanism set up to prevent that, but I am not sure of that.

COMMISSIONER FIRESTONE: The implication, therefore, is that while you are not for compulsion, you want to make quite sure that everybody in Prince Edward Island pays the same rate for the same services if he is to be covered? If you don't call it "compulsion" perhaps we can find a better word, and I am quite happy to accept any word for what we have in mind.

DR. MacMILLAN: I am not quite sure what Dr. Firestone is coming at, but if a group of people could compete in a carrier approved, or if the policy from Prince Edward Island happened to be in England or the United States, and a certain group

citizens of Prince Edward Island; is that the objective?

DR. COADY: We are proposing that any contract made available to any group of citizens of Prince Edward Island must be made available to all.

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DR. MacMILLAN: I am not quite sure what Dr. Firestone is coming at, but if a group of people could compete in a carrier approved, or if the policy from Prince Edward Island happened to be in England or the United States, and a certain group

wanted to go there, I don't think we would be opposed to this. Whether or not this would adversely affect the community rate of which you spoke -- this is quite possible. Unfortunately, the group which you picked, between twenty and fifty, is pretty wide and covers some of the services which are almost entirely covered under these plans, so that the example is not entirely right. However, we would oppose compulsion in the sense we would be opposed to compelling people to buy only a given plan, both compelling all people to take it and compelling them to have only this with no choice.

COMMISSIONER FIRESTONE: Well, I was going to be satisfied with my question, but since you re-opened it may I pursue the question one further minute or two?

How would you make your proposed rate work? You speak here of the community rate being struck. If you gave permission for this how would you then enforce this recommendation contained in paragraph 81, sub-paragraph 1?

DR. MacMILLAN: In practice, sir, the comprehensiveness of the benefits and the terms and conditions of the contracts would be so good that the assumption which you make would be very unlikely.

COMMISSIONER FIRESTONE: I understand we will have a further opportunity to question you. Thank you very much.

THE CHAIRMAN: Any further observations that you gentlemen want to make before we conclude this phase of this presentation?

Thank you very much, gentlemen.

DR. DEWAR: I would just like to say, Mr. Chairman, that we appreciate very much the extensive, searching hearing we have had here today, and I hope it will be of value to the Commission as they proceed to draw up their conclusions and make their reports. I would say again that we appreciate the time the Commission has spent reviewing our brief and giving

to be satisfied with my question, but since you re-opened it may I pursue the question one further minute or two?

How would you make your proposed rate work? You speak here of the community rate being struck. If you gave permission for this how would you then enforce this recommendation contained in paragraph 81, sub-paragraph 1?

DR. MacMILLAN: In practice, sir, the comprehensiveness of the benefits and the terms and conditions of the contracts would be so good that the assumption which you make would be very unlikely.

COMMISSIONER FIRESTONE: I understand we will have a further opportunity to question you. Thank you very much.

THE CHAIRMAN: Any further observations that you gentlemen want to make before we conclude this phase of this present hearing?

Thank you very much, gentlemen.

DR. DEWAR: I would just like to say, Mr. Chairman, that we appreciate very much the extensive, searching hearing we have had here today, and I hope it will be of value to the Commission as they proceed to draw up their conclusions and make their reports. I would say again that we appreciate the time the Commission has spent reviewing our brief and giving

us a fine hearing. Thank you very much.

THE SECRETARY: Mr. Chairman, may this be known as Exhibit 29, this particular submission?

THE CHAIRMAN: Yes.

EXHIBIT NO. 29: Submission of the Prince Edward Island Division of the Canadian Medical Association.

THE CHAIRMAN: We will now hear the submission of the Prince Edward Island Confederation of Home and School Associations.

SUBMISSION OF PRINCE EDWARD ISLAND FEDERATION OF HOME AND SCHOOL ASSOCIATIONS

EXHIBIT NO. 30: Submission

APPEARANCES:

Erie J. Kipping, President

MR. KIPPING: Mr. Chairman, members of the Commission, I was to have been accompanied today by other supporters from the Prince Edward Island Federation of Home and School Associations, but possibly the morning session was too much for them.

THE CHAIRMAN: Yes.

EXHIBIT NO. 29: Submission of the Prince Edward Island Division of the Canadian Medical Association.

THE CHAIRMAN: We will now hear the submission of the Prince Edward Island Confederation of Home and School Associations.

EXHIBIT NO. 30: Submission

MR. KIFFING: Mr. Chairman, members of the Commission, I was to have been accompanied today by other supporters from the Prince Edward Island Federation of Home and School Associations, but possibly the morning session was too much for them.

The Prince Edward Island Federation of Home and School Associations, consisting of 39 Associations throughout the Province, with a total membership of 2,000, in keeping with its prime aims, one of which is that of obtaining the best for each child according to his physical, mental, social and spiritual needs, welcomes this opportunity of presenting to the Royal Commission on Health Needs of Canada some viewpoints which we feel would be in the nature of preventative measures, and as such well suited to being carried out in the school setting.

I. Physical Needs

We wish to indicate our appreciation and support of the health programme which presently exists in the schools, especially the Health Inspection and Immunization service.

We would respectfully submit:

(a) That public health staff be increased in order that a more complete health programme be carried out in the schools and that special emphasis be placed on the teaching of general nutrition.

(b) That a complete screening of visual and auditory defects be carried out at the primary school level.

Such a health programme would help to develop a child's full potential and aid him to become a more effective member of society.

II. Mental and Emotional

Many mental and emotional problems could be brought to light in the early school years and steps

and School Associations, consisting of 39 Associations throughout the Province, with a total membership of [illegible] that of obtaining the best for each child according to his [illegible] this opportunity of presenting to the Royal Commission on Health Needs of Canada some viewpoints which we feel would be in the nature of preventative measures, and as such well suited to being carried out in the school [illegible].

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II. Mental and Emotional

Many mental and emotional problems could be brought to light in the early school years and steps

then taken to provide these children with an opportunity for healty development, if we had adequately trained teaching staff and personnel. We would recommend that:

(a) The present staff of two liaison teachers in the Province of Prince Edward Island be increased to at least seven;

(b) The Normal Training course be enriched with courses in Child Psychology, training in the Psychology of the Exceptional Child, Individual Differences and Personality Development;

(c) For those children who are found to be in the educable retarded group there be established Individual Advancement Classes (not more than 15 pupils in each) at convenient centres throughout the Province. Suggested centres would be those which already have established or will be establishing regional schools with transportation;

(d) For those children who belong in the trainable retarded group, day training classes be established throughout the Island;

(e) Many learning disorders, especially reading disability, are due to, or result in emotional problems. Early and accurate assessment of the problem, followed by remedial measures, would result in decrease in early school drop outs. We suggest that serious consideration be given to the feasability of establishing reading clinics at various centres. This would necessitate having several persons trained as

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reading specialists who would conduct those programmes.

III. Adult Education

The success of any programme is proportionate to the knowledge, skill and enthusiasm of those participating. We can realize an adequate mental health programme only when the public learns to regard mental and emotional illness in the same manner as they regard physical illness, and are prepared to accept the advice of trained personnel.

We therefore recommend that:

(a) An adequate education programme be instituted to remove the traditional stigma which has been associated, in the public eye, with mental illness;

(b) Sufficient centres be established for the treatment of emotional and mental disorders when these are discovered by early screening and diagnosis;

(c) This treatment be made available on the same basis as that provided for other types of illness.

IV. Conclusion

In conclusion we wish to express our appreciation for the opportunity of presenting this brief, and we hope that the material included therein will receive your serious consideration.

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IV. Conclusion

for the opportunity of presenting this brief, and we hope that the material included therein will receive your serious consideration.

THE CHAIRMAN: Thank you, Mr. Kipping. Do you wish to make any observations additional to what you have said?

MR. KIPPING: Without wishing to go into much further detail on these rather general and recommendations, sir, I could simply say that many of the points touched upon very lightly in our brief will be elaborated upon in the brief, for example, of the Canadian Mental Health Association, the P.E.I. Division, which follows shortly, and the Association for Retarded Children's brief. These will point out things which we have merely mentioned in passing.

THE CHAIRMAN: Have you had any pilot projects in this province with a view to screening visual and auditory defects, the two that you have mentioned here, to determine the incidence of it in the schools, or either one?

MR. KIPPING: As I understand it, the purpose of the two liaison teachers who are employed at present in this province, one who was to be with me today, Miss Eleanor MacDonald, liaison teacher for the City of Charlottetown, and the other, Miss Thompson for the province, do carry out a screening which includes the screening of visual defects.

THE CHAIRMAN: What about auditory?

MR. KIPPING: Auditory, as I understand it, is not looked into on the same scale and is somewhat neglected, as I understand it.

THE CHAIRMAN: Do you know anything about speech defect?

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MR. KIPPING: Auditory, as I understand it, is not looked into on the same scale and is somewhat neglected, as I understand it.

THE CHAIRMAN: Do you know anything about speech defect?

MR. KIPPING: They also screen for speech defect.

THE CHAIRMAN: You recommend increasing these two liaison teachers to seven. Have you estimated the cost?

MR. KIPPING: We estimate that the cost of the additional training required would consist of one year's additional training, approximately $2,000.00 for each person, plus the additional salary which they would command following their training.

THE CHAIRMAN: You go on a yearly basis?

MR. KIPPING: Yes.

THE CHAIRMAN: Where would that money come from? Have you any suggestions as to that? Do you tie this to education as part of education costs or as part of health costs?

MR. KIPPING: It might be a combining of the Departments of Education and of Public Health and Welfare, I would think. I can't see it coming from any other source.

COMMISSIONER BALTZAN: I have no questions, Mr. Chairman. I may comment only that these are very admirable objectives.

COMMISSIONER GIRARD: Mr. Kipping, as to physical needs, No. I, you state that public health staff be increased in order that a more complete health program be carried out in the schools. Would you please tell us what in your mind would be a complete health program or how you would like to do it, to make the health program in the schools more

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physical needs, No. 1, you state that public health staff be increased in order that a more complete health program be carried out in the schools. Would you please tell us what in your mind would be a complete health program or how you would like to do it, to make the health program in the schools more

complete?

MR. KIPPING: Well, at the present time we feel there is a lack of time on the part of the present public health nurses to devote their attention to home nursing training for some of the high school girls, and it is thought also -- this thought has only recently come to us -- that in view of the accelerated civil defence program this might be a desirable thing at the moment, more emphasis on home nursing. Apparently the text books in use are not all they might be. It has been mentioned that the very latest text books be obtained and put into use, and these in all grades. At the moment the high schools do not receive in our opinion sufficient attention of the public health nurse.

COMMISSIONER GIRARD: But, Mr. Kipping, this is under physical needs. Are there any other physical needs that you can see that are not taken care of?

MR. KIPPING: The auditory defects apparently are not being detected, and this would be one physical need. I am sorry, I can't go into that in much more detail than this.

COMMISSIONER GIRARD: Possibly this will come up when the nurses give their brief.

MR. KIPPING: I think so.

COMMISSIONER GIRARD: Thank you very much, Mr. Kipping.

THE CHAIRMAN: Thank you very much, Mr. Kipping.

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MR. KIPPING: Well, at the present time we present public health nurses to devote their attention to home nursing training for some of the high school girls, and it is thought also -- this thought has only recently come to us -- that in view of the accelerated civil defence program this might be a desirable thing at the moment, more emphasis on home nursing. Apparently the text books in use are not all they might be. It has been mentioned that the very latest text books be obtained and put into use, and these in all grades. At the moment the high schools do not receive in our opinion sufficient attention of the public health nurses.

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MR. KIPPING: I think so.

COMMISSIONER GIBARD: Thank you very much, Mr. Kipping.

MR. KIPPING: Thank you, Mr. Chairman and members of the Commission.

THE CHAIRMAN: We will now hear the submission by the Prince Edward Island Dental Association.

MR. KIPPING: Thank you, Mr. Chairman and members of the Committee.

THE MINISTER: Mr. Bill Walker, the Minister, by the Prince Edward Island Dental Association.

SUBMISSION OF PRINCE EDWARD ISLAND DENTAL ASSOCIATION

---EXHIBIT NO. 31

APPEARANCES:

Alan Stewart

Gerald D. Barrett

B.J. O'Meara

R.G. Romcke

A.L. MacIsaac

DR. BARRETT: Mr. Chairman and gentlemen, my name is Dr. Barrett. This is Dr. Stewart, and with me I have Dr. MacIsaac, Dr. Romcke and Dr. O'Meara.

In the deliberations which lead up to the writing of this brief we attempted to follow the terms of reference to the letter, and we also noted your stress on the point that the submissions should be precise and to the point, and we have attempted to do exactly that. We have edited our brief to the essentials consistent with airing our views. We have pointed this out so that the Commission will not think we have made this hurriedly or without due thought. I have noticed that some of even the summaries that have been submitted seem to be as large as our entire brief. We hope we have not been over zealous in making our brief overly brief. Therefore I would request permission to submit the main body of our brief to the Commission so that all the conditions may be heard. Our summary is in the introduction of our brief.

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TORONTO, ONTARIO

SUBMISSION OF BRITISH EDMUND TRIANG MENTAL ASSOCIATION
--EXHIBIT No. 11

Witnesses:

Alan Stewart

Gerald D. Barrett

J.C. Gibbens

R.G. Homewe

E.L. Meslenko

DR. BARRETT: Mr. Chairman and gentlemen, my name is Dr. Barrett. This is Dr. Stewart, and with me I have Dr. Meslenko, Dr. Homewe and Dr. Gibbens.

In the deliberations which lead up to the writing of this brief we attempted to utilize the terms of reference to the letter, and we also noted your stress on the point that the submissions should be precise and to the point, and we have attempted to do exactly that. We have edited our brief to the essentials consistent with stating our views. We have pointed this out so that the Commission will not think we have made this hurriedly or without due thought. I have noticed that some of even the summaries that have been submitted seem to be as large as our entire brief. We hope we have not been over zealous in making our brief overly brief. Therefore I would request permission to submit the main body of our brief to the Commission so that all the conditions may be heard. Our summary is in the introduction of our brief.

The Dental Association of Prince Edward Island, the duly appointed body representing the practising dentists of Prince Edward Island and having as its main objective the provision of the best possible dental health care for the people of Prince Edward Island:

I recognizes the request of the Prime Minister of Canada, the Right Honourable John Deifenbaker, that a survey of existing health services in Canada be made, and

II recognizes the appointment by the Privy Council of a Royal Commission to carry out this survey on existing and future needs of health services in Canada, and

III in response to a request by this Royal Commission, and being aware that dentistry forms an integral part of health services, is grateful for the privilege of submitting the following brief, having first adopted the terms of reference as laid down by the Royal Commission.

Representing the Prince Edward Island Dental Association:

Alan Stewart, D.D.S.
President, P.E.I. Dental Association

Gerald D. Barrett, D.D.S.
Secretary-Registrar, P.E.I. Dental Association

B. J. O'Meara, D.D.S., D.D.P.H.

R. G. Romcke, D.D.S.

A. L. MacIsaac, D.D.S.

Instead, the duly appointed body representing the [illegible] having as its main objective the provision of the best possible dental health care for the people of Prince [illegible]:

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Representing the Prince Edward Island Dental [illegible]

Alan Stewart, D.D.S.
President, P.E.I. Dental Association

[illegible]

A. L. Maclaren, D.D.S.

INTRODUCTION

1. The Prince Edward Island Dental Association in submitting this brief believes that the dental health of the people in this province will be better served by an expansion of the present facilities, as will be explained, than by any programme of state controlled dental services. The proposals that we offer would retain the vital patient-dentist relationship -- which infers:

(a) freedom of choice of the dentist by the patient.

(b) freedom of choice by the dentist to treat the patient.

(c) the complete freedom of judgement and responsibility in rendering dental services by the dentist.

(d) the right of the patient to accept or reject the treatment offered.

2. The points that will be covered in the brief note that the first requirement is the reduction of dental disease by preventive measures, particularly fluoridation of communal water supplies, topical application of fluorides, and education in good food habits and better oral hygiene.

3. At present there are twenty-five dentists engaged in private practice; two dentists and two dental hygienists employed by the Provincial Department of Health. These practising dentists are located chiefly in urban areas and therefore the greatest need exists in our rural areas.

In submitting this brief believes that the dental health an expansion of the present facilities, as will be explained, then by any programme of state controlled dental services. The proposals that we offer would inform:

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The points that will be covered in the brief note that the first requirement is the reduction of dental disease by preventive measures, particularly fluoridation of commercial water supplies, topical application of fluorides, and education in good food habits and better oral hygiene.

At present there are about five dentists employed in private practice; two dentists and two dental hygienists employed by the Provincial Department of Health. These practising dentists are located chiefly in urban areas and therefore the greatest need exists in our rural areas.

Approximately two-thirds of the population are not receiving adequate dental care. However, the present dental services cope reasonably well with the present demand. In order to improve the dental services, it is necessary to increase the demand. In order to increase the demand, we recommend:

I Increased education in the need for dental health.

II Pre-paid dental care programmes administered by the profession.

III Government financial assistance for those unable to pay.

In order to cope with the increased demand, we propose an increase in the number of personnel through government-subsidized training plans for dental students, and, after graduation, financial assistance in the establishment of dental offices in rural centres. They would then be under contract for a limited period to practise only in rural centres, doing part-time school dentistry.

4. We believe that at present six additional dentists would be required for this programme and, in addition, two or three dentists per year to replace those going out of practice throughout the province.

5. It would be essential to establish priorities of treatment. First consideration would be given to children in the younger age groups and gradually including the older age groups as the plan progresses

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THE EXISTING FACILITIES AND METHODS FOR PROVIDING PERSONAL HEALTH SERVICES, INCLUDING PREVENTION, DIAGNOSIS, TREATMENT, AND REHABILITATION.

6. The existing facilities for the provision of dental treatment to the people of Prince Edward Island consist of:

(a) Twenty-five dentists in private practice and two dentists employed full-time doing public health dentistry. Seven of the above named twenty-five private practitioners carry out part-time work in public health dentistry.

(b) Two to three dental hygienists employed in the preventive aspects of dentistry, including the topical application of stannous fluoride, school survey, and dental education in the schools.

(c) The services of the bacteriological and pathological departments of the Provincial Department of Health which are available to the profession.

(d) Three dental laboratories in the province each employing one dental technician.

(e) Clinics in the urban areas providing treatment for indigent children and for children in the orphanages. In rural areas, children in Grades 1 and 2 are accepted for treatment at a mobile dental unit or in the dental offices of the rural dentists.

(f) A preventive orthodontic clinic operated by

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(f) [illegible]

the Provincial Department of Health.

(g) Treatment given to patients of Riverside Mental Hospital at a clinic located there.

METHODS OF IMPROVING SUCH EXISTING HEALTH SERVICES

7. From available statistics it is apparent that under existing conditions two-thirds of the population do not receive adequate dental care. However, it must be remembered that a considerable proportion of our population is in the three-year-old and under age groups and in the older age groups where only a minimum amount of dental treatment is required. The present number of dentists in P.E.I. is coping reasonably adequately with the existing demand. Thus, to improve the situation, it is necessary through patient education to:

(a) Increase the demand for dental service -- Appendix I.

(b) Provide the personnel to cope with this increased demand -- Appendix II.

THE CORRELATION OF ANY NEW OR IMPROVED PROGRAM WITH EXISTING SERVICES WITH A VIEW TO PROVIDING IMPROVED HEALTH SERVICES.

8. Since the suggestions for improving dental services are based on the expansion of those at present existing, there should be no problem of correlation.

THE PRESENT AND FUTURE REQUIREMENTS OF PERSONNEL TO PROVIDE HEALTH SERVICES.

9. <u>Present:</u>

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THE PERSONNEL AND FURTHER REQUIREMENTS OF PERSONNEL TO PROVIDE HEALTH SERVICES

Six additional dentists for P.E.I. centred mainly outside the two large urban centres, with financial inducement to hold them there. These dentists would also do part-time school clinic work. Two additional dental hygienists for the Department of Health.

10. Future:

Future requirements are dependent on a number of factors:

I Increased demand for services.

II Introduction of fluoridation of communal water supplies in larger centres.

III Increased use of topical fluoride.

IV Success of recently introduced fluoride incorporated tooth-pastes.

V Increase in work output through further technological improvements in dental equipment.

VI Major breakthrough in dental research.

NOTE:

11. Demand at present in P.E.I. hardly exceeds the existing facilities. Generally speaking, once the optimum number of dentists has been attained, an additional two to three per year would be required. Also, a continuous staff of six to eight Hygienists is required in Public Health. These changes will gradually increase the demand and at the same time supply additional services to cope with the demand.

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METHODS OF PROVIDING ADEQUATE PERSONNEL WITH THE BEST POSSIBLE TRAINING AND QUALIFICATIONS FOR

SUCH SERVICES.

12. I Excellent training is presently available in the Maritimes at Dalhousie University for dentists and dental hygienists.

II Under the present training programme at Dalhousie University existing qualifications of graduates are adequate.

III Post-graduate refresher training is also available at Dalhousie and the programme is under expansion. In order to encourage greater participation by the general practitioner, we believe the expenses incurred should be an allowable income tax deduction.

IV In our opinion, more facilities are required for the formal training of dental technicians and dental assistants by the dental profession.

V Inclusion of facilities and financial assistance for post-graduate training by practising dentists is desirable in specialized courses leading to a degree.

THE PRESENT PHYSICAL FACILITIES AND THE FUTURE REQUIREMENTS FOR THE PROVISION OF ADEQUATE HEALTH SERVICES.

13. Present

(a) Most existing dental offices are adequately equipped and keep pace with improved technical equipment. This further increases work output of individual offices.

(b) Stationary and mobile clinics are operated by the Department of Health.

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14. Future

(a) Facilities for dental treatment in hospitals. This is at the present time completely lacking. A clinic centred at a hospital staffed by a salaried dentist could render emergency treatment, and care for those unable to pay.

(b) Expansion of dental offices by the use of additional chairs, with increased use of hygienists and assistants.

THE ESTIMATED COST OF HEALTH SERVICES NOW BEING RENDERED CANADIANS, WITH PROJECTED COSTS OF ANY CHANGES THAT MAY BE RECOMMENDED FOR THE EXTENSION OF EXISTING PROGRAMMES OR FOR ANY NEW PROGRAMMES SUGGESTED.

15. The estimated cost of health services now being rendered to Canadians will be brought out in detail in the brief submitted by the Canadian Dental Association using the statistical information they have available. We are at the present time unable to estimate the cost of health services now being rendered, nor the projected costs of changes which we recommend.

THE METHODS OF FINANCING HEALTH CARE SERVICES AS PRESENTLY SPONSORED BY MANAGEMENT, LABOUR, PROFESSIONAL ASSOCIATIONS, INSURANCE COMPANIES, OR IN ANY OTHER MANNER.

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THE METHODS OF HINANCING HEALTH CARE SERVICES WHICH PRESENTLY SPONSORED BY MANAGEMENT, LABOUR, FED [illegible] NATIONAL [illegible] IN ANY OTHER MANNER.

Other than the dental health care programs by

the individual dentist and paid for by the patients themselves, the only other services available are those provided and paid for by the Department of Health.

THE METHODS OF FINANCING ANY NEW OR EXTENDED PROGRAM WHICH MAY BE RECOMMENDED.

17. I. A pre-payment or post-payment plan, operated on the principles for those outlined by the committee on Health Insurance Studies of the C.D.A.

II Government assistance to communities for the installation of fluoridation systems.

III The training of dentists and dental hygienists would require subsidizing by the government.

IV Financial assistance by the government for those establishing dental offices in rural areas.

THE FEASIBILITY AND DESIRABILITY OF PRIORITIES IN THE DEVELOPMENT OF HEALTH CARE SERVICES.

18. It would be not only desirable but essential to establish priorities in the development of dental health services. Also, the establishment of priorities would have to be sharply graded so as not to disrupt the services already given.

19. In this regard, first consideration should be given to young children and expectant mothers, and then to the aged. If, and when, it became possible to cope with these, then progressively older children

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IV. I. A pre-payment or post-payment plan, operated on the principles for these outlined by the committee on health insurance studies of the

II Government assistance to communities for the installation of fluoridation systems.

III The training of dentists and dental hygienists would require subsidizing by the government.

IV Financial assistance by the government for those establishing dental clinics in rural areas.

THE FEASIBILITY AND DESIRABILITY OF PRIORITIES IN THE DEVELOPMENT OF HEALTH CARE SERVICES.

18. It would be not only desirable but essential to establish priorities in the development of dental health services. Also, the establishment of priorities would have to be sharply graded so as not to disrupt the services already given.

19. In this regard, first consideration should be given to young children and expectant mothers, secondly to the aged. If, and when, it became possible to

could be included. Only by some gradual progression could an orderly development of dental health services be established and so eventually develop into complete comprehensive care.

APPENDIX I -- METHODS OF INCREASING THE DEMAND.

I Education

The addition of the personnel mentioned in Appendix II, together with existing personnel, would enable a further increase in the programme of dental education necessary to create a greater demand for services, and in the promotion and application of existing proven preventive measures such as fluoridation of communal water supplies and topical application of stannous fluoride to the teeth of children.

II Pre-paid dental programmes administered by the profession and operated on sound insurance principles. This type of programme covers everyone. The premiums for the lower income groups would be paid by the federal and/or provincial governments.

III Elimination of apathy and fear complex among patients through education and sympathetic treatment, combined with modern methods of pain elimination.

IV Improved education in oral hygiene and nutrition.

These recommendations, if properly carried out, could provide an eventual solution to the problem of dental care for all, but a considerable period of time would be necessary to carry out these changes.

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APPENDIX II -- METHODS OF INCREASING THE NUMBER OF DENTAL PERSONNEL

I Dentists

(a) An active recruitment program carried out by members of the profession through contact with high school students in our dental offices, in high school assemblies, youth groups, etc.

(b) Training plans subsidized by either provincial and/or federal governments, such as is being done in Newfoundland

NOTE

The new Dental School at Dalhousie University has now nearly enough facilities to handle the proposed necessary increase in dentists and auxiliary personnel. As yet, the existing facilities have not been fully utilized. In the future as more personnel become available and demand increases, it may be necessary for Dalhousie to expand accordingly.

II Auxiliary Personnel

Properly qualified and recognized dental auxiliaries (dental hygienists, dental assistants, dental technicians) could be trained to render a broader scope of service than that presently recommended. The training of these auxiliaries must be under the direction of the dental profession. Dalhousie University has recently begun this programme by instituting a training

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course for dental hygienists. The services that these auxiliaries are qualified to render must be included in the prescribed training programme and must be under the direction and supervision of a qualified dentist.

MR. HALL: Doctor, referring to page 2, paragraph 3 of your submission, could you tell the Commission exactly how many of the practising dentists are located in the urban areas?

DR. BARRETT: Twenty-three are in urban areas.

THE CHAIRMAN: Out of twenty-five?

DR. BARRETT: No.

THE CHAIRMAN: Well, at the present time there are twenty-five dentists engaged in private practice?

DR. STEWART: The public service dentists were include erroneously.

MR. HALL: Reference is also made in that paragraph, doctor, to a statement: "Approximately two-thirds of the population are not receiving adequate dental care". How do you arrive at that portion, is that an estimate, a survey that you made, or?

DR. BARRETT: This is based on statistics that have been made available to the country by the Canadian Dental Association. This is a well known fact, I believe, that two-thirds of the people do not receive adequate dental treatment.

THE CHAIRMAN: In Prince Edward Island , or elsewhere?

DR. BARRETT: I think so.

THE CHAIRMAN: I mean, that is what you are saying?

DR. BARRETT: I think so.

THE CHAIRMAN: How do you define rural, in terms of Prince Edward Island?

DR. O'MEARA: We include Charlottetown,

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THE CHAIRMAN: How do you define rural, in terms of Prince Edward Island?

DR. O'MEARA: We include Charlottetown,

Summerside and Mountain View as being urban areas, and the smaller communities are included in the rural areas.

THE CHAIRMAN: Could you suggest by and large how far, how many people of one group are away from a practising dentist? How far would the most distant person be from any practising dentist?

DR. O'MEARA: At the most, 70 miles or so.

THE CHAIRMAN: From any dentist at all?

DR. O'MEARA: Well, if you go to the extreme east, there are no dentists in Souris. Probably the nearest, no perhaps that is wrong. I would say 50 then. The western part of the province is even worse off than that.

MR. HALL: Paragraph 3 sub-paragraph 1, on page 2. Would you describe for the Commission, doctor, what at the present time your dental health education program consists of, what you think it lacks, how it could be improved?

DR. BARRETT: Would you repeat that?

MR. HALL: Could you describe what the present dental health education program consists of, what you think it lacks, and how you think it could be improved, and in what manner it could be improved?

DR. BARRETT: Well, we have dental hygienists. Two or three dental hygienists who visit the schools in rural areas and the urban areas,but they are unable to get around to all the schools, and the amount of time they can spend in individual schools is very limited, and they examine the children in the urban

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areas and give individual dental health education, and also in the classrooms. Does that cover what you want to know?

MR. HALL: Partly, doctor, yes. What more do you recommend, if anything?

DR. O'MEARA: Well, certainly more dental hygienists from the point of view of dental health education, a sufficient, and we mentioned up to eight dental hygienists, who could give a more thorough dental health education program.

MR. HALL: Page 4, paragraph 6, sub-paragraph F. Reference is made to a preventive orthodontic clinic, operated by the provincial Department of Health. Are you able to tell the Commission how effective that has been, in your opinion, and whether you recommend such a clinic as a matter of principle?

DR. O'MEARA: I myself carry out that program. It is a pilot program in Canada I think, under the Department of Health at any rate. It certainly has much greater scope for enlargement, but it is serving a very useful purpose, I am sure.

MR. HALL: How long has it been in operation?

DR. O'MEARA: About four or five years.

MR. HALL: On page 5, paragraph 10, sub-paragraph 2. Would you tell the Commission whether or not any communal water supplies on the island are at present fluoridated?

DR. BARRETT: There are none.

MR. HALL: Can you tell the Commission whether or not there is legislative provision for the provision

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DR. BARRETT: There are none.

MR. HALL: Can you tell the Commission whether or not there is legislative provision for the provision

of supplying fluoridation water?

DR. O'MEARA: There is no provision in legislation for the fluoridation. There has been no change in the Act since the question of fluoridation arose. There has been nothing in the Act to have fluoridation if the community so wishes.

THE CHAIRMAN: If the community desired to have fluoridation, what process would have to be followed?

DR. O'MEARA: As far as I know, Mr. Chairman, they could go straight ahead and do so. There is no legal objection to them doing so.

THE CHAIRMAN: Nor no provision for a vote, or a referendum, or anything of that kind?

DR. O'MEARA: Well, we did have a referendum here nearly two years ago, but that was at the choice of the Water Commissioners of Charlottetown. It was at their request that the plebiscite was held.

COMMISSIONER McCUTCHEON: What was the result of that referendum?

DR. O'MEARA: It was lost by twenty-seven votes, and it was to be on a majority decision.

COMMISSIONER McCUTCHEON: I take it that your Association believes that communal water supplies should be fluoridated?

DR. O'MEARA: Very much so, sir, yes.

MR. HALL: On page 6, paragraph 13A, starting equipment of dental offices. Will you tell the Commission whether all or some of the dental offices have high speed equipment of recent design?

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DR. O'MEARA: Very much so, sir; yes.

MR. HALL: On page 5, paragraph 13A, starting equipment of dental offices. Will you tell the Commission whether all or some of the dental offices have high speed equipment of recent design?

My information is that there has in the past several years been new equipment produced.

DR. BARRETT: I should think that the majority have high speed equipment now.

MR. HALL: You have no definite information on that?

MR. BARRETT: No, I have no definite figures. Dr. Stewart just whispered in my ear that he would say 90 per cent.

MR.HALL: On page 9, appendix 1, paragraph 2. Where would your recommendation of clinic staff by salaried dentists as set out in paragraph 14, fit into a program such as that referred to in paragraph 2 of the appendix?

DR. BARRETT: Is that where we refer to the clinic in the hospital?

MR. HALL: Yes. Would such a clinic be necessary if you had the program you refer to in the appendix, or is that in addition to it?

DR. BARRETT: I think it would be in addition to it.

COMMISSIONER STRACHAN: Page 4, paragraph 6b: to what extent are the hygienists used? What areas do they cover at the present time?

DR. O'MEARA: We have clinics in Charlottetown and in Summerside which run most of the summer months. Dental hygienists ususally work in the schools during the school year, but in the spring, they generally start with the fluoride program in the clinics in Charlottetown, Summerside and then in different rural areas each year -- one or two rural areas, according to the demand on the clinics.

COMMISSIONER STRACHAN: Do I understand that the greater concentration of their services is in the two recognized urban areas rather than in the outlying areas?

DR. O'MEARA: Well, of course, a big problem of the outlining areas is to have sufficient children to come into a rural centre, whereas, particularly in the summertime, the rural people do get more into the urban areas.

COMMISSIONER STRACHAN: Do these hygienists not go into the schools?

DR. O'MEARA: To give this treatment?

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MR. HALL: Yes. Would such a clinic be necessary if you had the program you refer to in the appendix, or is that in addition to it?

DR. BARNETT: I think it would be in addition to it.

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COMMISSIONER STRACHAN: Yes.

DR. O'MEARA: No; it is done in clinics.

COMMISSIONER STRACHAN: In clinics?

DR. O'MEARA: That is right. Sometimes those clinics in the rural areas may be stationed in a school.

COMMISSIONER STRACHAN: I see reference is made in 6e to a mobile dental unit: what is its use, and do the hygienists work in that at all?

DR. O'MEARA: No, we have a dentist giving straight dental treatment there, but we did try having the dental hygienists working in those clinics, but it wasn't too satisfactory.

COMMISSIONER STRACHAN: Then, is this mobile dental unit in constant use in outlying areas?

DR. O'MEARA: Except for about two or three months in the early part of the year from January to mid March on account of weather conditions.

COMMISSIONER STRACHAN: But the operator confines his services to Grade I and Grade II?

DR. O'MEARA: Yes, sir.

COMMISSIONER STRACHAN: Following up to 6f regarding orthodontic treatment, that is, by the provincial Department of Health, how do you find these patients?

DR. O'MEARA: They are referred to me by the dentists.

COMMISSIONER STRACHAN: Are the dentists themselves not doing any preventive orthodontic work?

DR. O'MEARA: There are some dentists who do

COMMISSIONER STRACHAN: Yes.

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DR. O'MEARA: There are some dentists who do

quite a lot of orthdontic work, but these are more for the people in more modest circumstances. It was not meant to cover everybody nor is it meant to be a full orthdontic treatment clinic.

COMMISSIONER STRACHAN: I think I am right in assuming that there is no qualified orthodontist here: where do you have to refer patients for advanced and difficult orthdontic treatment?

DR. O'MEARA: There are two dentists here in Charlottetown who have done orthdontic work for many years,but the nearest specialist is Moncton.

COMMISSIONER STRACHAN: I am happy to hear there are men here who have carried on through the years. It is a very valuable service to the community.

Page 6, paragraph 14, facilities for dental treatment in hospitals. You point out there is no clinic: what use are the dentists permitted to make of a hospital?

DR. STEWART: We are allowed the use of the operating room subject to the admission of the patient into hospital by a qualified physician. Some of the restricted members are not allowed to write orders, but any orders must be written by a physician, and it is the responsibility of the physician while the patient is in hospital. We are merely utilizing the operating room.

COMMISSIONER STRACHAN: There is no bar to that at all?

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COMMISSIONER STRACHAN: There is no bar to that at all?

DR. STEWART: [illegible]

harmony.

COMMISSIONER STRACHAN: Turning now to page 7, paragraph 16, you point out how dental care is provided, and I should think this island would be very unique if considerable dental service was not rendered by the dentists themselves without payment on at least some occasions, because I am quite certain that no one with an acute dental condition is being refused treatment whether they can pay or not. Am I correct?

DR. STEWART: That is correct.

COMMISSIONER STRACHAN: I am sure the members of the Commission should be interested in knowing that fact.

COMMISSIONER VAN WART: Might I ask a question on the use of mobile clinics, by grades 1 and 2: are they well patronized?

DR. O'MEARA: Yes sir, they are. It is difficult to say the proportion of the children available to make use of them -- about 80 per cent I am told.

COMMISSIONER VAN WART: About 80?

DR. O'MEARA: Eighty per cent.

COMMISSIONER VAN WART: And have you a working agreement with the public health nurses that they round up these children, or what is the means of arriving at the clinic?

DR. O'MEARA: Well, the nurses certainly render very valuable assistance there in advertising the clinics in the schools and arranging appointments

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for the children at the clinics.

COMMISSIONER VAN WART: One other question in regard to in-hospital service: have dentists any arrangements with the medical profession for the treatment of fractures of the jaw?

DR. STEWART: I can only speak for Summerside, but any cases since I have been in practice, the dentist does the fracture cases and calls in a consultant or recommends they be referred to an oral surgeon, the nearest one being Halifax.

COMMISSIONER VAN WART: The responsibility is taken by the practicing physician?

DR. STEWART: Yes, it is. It must be assumed under the present Act in the hospital that the patient is the responsibility of the physician.

COMMISSIONER VAN WART: And if it is a Workman's Compensation case are you paid directly or are you paid through the doctor?

DR. BARRETT: I have done such cases and been paid by the Workman's Compensation.

COMMISSIONER VAN WART: Directly?

DR. BARRETT: Directly.

COMMISSIONER STRACHAN: What if they were insured under Blue Cross or some other form?

DR. BARRETT: No, I am not paid by Blue Cross.

THE CHAIRMAN: There is no coverage available under Blue Cross for dental services?

DR. BARRETT: No, sir.

THE CHAIRMAN: Not in Prince Edward Island?

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THE CHAIRMAN: Not in Prince Edward Island?

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COMMISSIONER BALTZAN: Just one question: have you approached hospital boards to form a department of dentistry comparable to other departmentalizations that are practically universal in all substantially large hospitals, so that you do not necessarily come under, say, an admitting physician or practitioner, and you observe the rules and regulations of the hospital as constituted by the hospital? My question is, have you approached any of these hospitals to form a department of dentistry?

DR. BARRETT: No.

DR. O'MEARA: As far as I know, that has not been done sir. I don't know of such a thing.

COMMISSIONER BALTZAN: May I ask you this, that this is a pretty general trend in other places: are you aware of that?

DR. BARRETT: Yes.

COMMISSIONER FIRESTONE: Dr. Barrett, I would like to say first of all that I had a personal experience yesterday with one of the dentists on the island. I needed some help and he gave it to me quickly, competently, and courteously, and if all dentists are like the one sample I have had, the island is well served, and I want to say thank you.

I have two questions: you recommend a prepaid dental care program administered by the profession, and you suggest government financial assistance for those unable to pay -- paragraph 3 on page 2. If the government contributes to a prepaid dental care program would you say that the

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government should also have a say in administering such a program? Would you like to let us know that at a later stage so that you can discuss it? We are interested in your genuine views.

DR. BARRETT: It is my view the plan should be administered by the profession.

COMMISSIONER FIRESTONE: And the government should have no say although they contribute financially to it? May I repeat my offer for further consultation among you and your colleagues?

DR. BARRETT: Perhaps.

COMMISSIONER FIRESTONE: Because the second question is touching on the first one, and that is, you have proposed such a program for the island: could your Association make an estimate as to what such a program would cost and where, in your opinion, the money should come from to pay for such a program, and would it be possible to let us have this information in writing on a subsequent occasion?

DR. BARRETT: We have talked a great deal about that, and the conclusion we arrived at was so general, and we were so uncertain of our facts, I would imagine any submission we would make would be like that.

COMMISSIONER FIRESTONE: But now you have received a specific request, would it be possible to consider the matter further and perhaps do a little homework so that in making a submission to the Commission we would know what is involved financially and what you recommend?

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DR. BARNETT: We have talked a great deal about that, and the conclusion we arrived at was so general, and we were so uncertain of our facts, I would imagine any submission we would make would be like that.

COMMISSIONER FIRESTONE: But now you have received a specific request, would it be possible to consider the matter further and perhaps do a little homework so that in making a submission to the Commission we would know what is involved financially and what you recommend?

DR. BARRETT: Yes.

COMMISSIONER FIRESTONE: And how it is to be paid for? After all, if the Commission doesn't have the advice from the people that are on the spot, where are we going to get that advice? So, can we get it from you?

DR. BARRETT: Yes, sir.

COMMISSIONER STRACHAN: Mr. Chairman, I would like to suggest that there are other members of the dental profession here, some that have been held in high regard for many years by the profession throughout Canada, and I want them to understand they will be free to express any opinions relative to the matter under discussion without being asked to do so. They may not wish to, but I think they should know the privilege is available to them.

THE CHAIRMAN: Yes. Before we conclude our consideration of this brief this afternoon, is there anyone else who has any observations to make pertaining to the subject under review?

Thank you very much, gentlemen.

DR. BARNETT: Yes.

COMMISSIONER FIRSTBROOK: And how it is to have the advice from the people that are on the [illegible] can we get it from you?

DR. BARNETT: Yes, sir.

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THE CHAIRMAN: Yes. Before we continue our consideration of this brief this afternoon, is there anyone else who has any observations to make pertaining to the subject under review?

Thank you very much, gentlemen.

SUBMISSION OF THE ASSOCIATION OF NURSES OF PRINCE EDWARD ISLAND

Appearances: Miss Ida MacKay
Mrs. Bolger
Sister Mary Irene

--- EXHIBIT NO. 31: Submission of the Association of Nurses of Prince Edward Island.

SUBMISSION ON HEALTH NEEDS PERTAINING TO NURSING

Preamble

The members of the Association of Nurses of Prince Edward Island deem it a singular privilege and honour to have this opportunity to present a statement on the nursing needs of our people to the Royal Commission on Health Services.

May we say at the outset that although we are aware of a number of vital needs in the areas of nursing service and nursing education, we are not prepared at this time to make specific recommendations as to methods of fulfilling these needs. We are participating in three studies which are being conducted by the Canadian Nurses' Association in the areas of nursing service and nursing education. In addition we are conducting a local study on Nursing Service Requirements in General Hospitals under the auspices of the Nursing Advisory Committee to the Hospital Services Commission.

We earnestly hope that at the time supplementary briefs are being presented to the Royal Commission, we will have made sufficient progress with our studies to be in a position to make recommendations on ways and means of meeting nursing needs in this Province.

SUBMISSION OF THE ASSOCIATION OF NURSES OF PRINCE EDWARD ISLAND

Mrs. Bolger
Miss Van Dyke

Commission of the Association of Nurses of Prince Edward Island.

SUBMISSION ON HEALTH NEEDS PERTAINING TO NURSING

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We earnestly hope that at the time supplementary briefs are being presented to the Royal Commission, we will have some satisfactory proposal with regard to a practical or even theoretical solution of meeting nursing needs in this Province.

Legislation for Nurses and Nursing Assistants

The first registration Act for nurses was passed in 1922 and at that time affiliation with the Canadian Nurses' Association was established.

In 1949 a mandatory Licensure Act was passed for the express purpose of raising the standards of nursing service and nursing education. This piece of legislation, in effect, implemented a number of recommendations of the Weir Report. (A Survey of Nursing Education in Canada by G.M. Weir, 1932)

In 1952 an Act to Provide for the Training, Licensing and Practice of Nursing Auxiliary Personnel was assenced to in the Legislature. This Act was not implemented until 1959. (Copies of both Acts are attached for your information).

Association of Nurses

Objectives:

1. To raise the standards of nursing service
2. To improve educational programmes for nurses with a view to improving the quality of nursing care
3. To improve personnel policies for nurses
4. To work with the allied health professions for the improvement of health services.

Membership Statistics January 1, 1961 - September 30, 1961:

Total membership - 479

Practising - 403

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2. To improve educational programmes for nurses with a view to improving the [illegible]
3. To improve personnel policies for nurses
4. To work with the allied health professions for the improvement of health services.

Membership Statistics January 1, 1961 - September 30, 1961:

Resident	- 371	
Non-Resident	- 32	
Non-Practising		- 76
Resident	- 49	
Non-Resident	- 27	

(The membership is so limited that the organization cannot function without financial assistance from another source, this is allocated from General Public Health Grants through the Department of Health. Provision is made for the salary of a School of Nursing Adviser, part-time, and free office space).

It is significant to note that the ratio of resident practising members to population is 1 to 268.

Statistical Information on Nursing Service Personnel

Numbers of Nursing Service Personnel Presently Employed in Hospitals and Health Agencies in Prince Edward Island:

Hospitals for Acutely Ill

Hospital Administrators	-	8 (6 are nurses)
Registered Nurses	-	(185)
Supervisors	-	40
Head Nurses	-	22
Staff Nurses	-	123
Students of Nursing	-	174
Licensed Nursing Assistants	-	53
Pupil Nursing Assistants	-	19
Orderlies	-	21
Ward Secretaries	-	5
Other (Ward Aides, ward maids, nurses' aides)	-	36

Resident	-	371
Non-Resident	-	32

(The membership is so limited that the

from another source, this is allocated from General Public Health Grants through the Department of Health. Provision is made for the salary of a School of Nursing Adviser, part-time, and free office space).

It is significant to note that the ratio of resident practising members to population is 1 to 268.

Statistical Information on Nursing Service Personnel

Numbers of Nursing Service Personnel

Hospitals for Acute Care

Hospital Administrators	-	8 (6 are
Registered Nurses	-	(165)
Supervisors	-	40
Head Nurses	-	21
Staff Nurses	-	123
Students of Nursing	-	144
Licensed Nursing Assistants	-	33
Pupil Nursing Assistants	-	70

Ward Secretaries	-	5
Other (Ward Aides, ward maids, nurses' aides)	-	35

Georgraphic Distribution of Nursing Service Personnel Prince Edward Island Hospital, Charlottetown

(Daily average number of patients - 123)

Supervisors	9
Head Nurses	10
Staff Nurses	31
Students of Nursing	63
Pupil Nursing Assistants	6
Nursing Assistants and Aides	19
Orderlies	8

Charlottetown Hospital, Charlottetown

(Daily average number of patients - 126)

Supervisors	11
Head Nurses	5
Staff Nurses	32
Students of Nursing	78
Pupil Nursing Assistants	6
Nursing Assistants and Aides	14
Orderlies	5

Prince County Hospital, Summerside

(Daily average number of patients - 86)

Supervisors	13
Head Nurses	1
Staff Nurses	26
Students of Nursing	45
Pupil Nursing Assistants	5
Nursing Assistants and Aides	23
Orderlies	3

Western Hospital, Alberton

(Daily average number of patients - 27)

Geographic Distribution of Nursing Service

(Daily average number of patients - 123)

Supervisors	9
Head Nurses	10
[illegible]	[illegible]
[illegible]	
Pupil Nursing Assistants	6
Nursing Assistants and Aides	15
[illegible]	
[illegible]	

(Daily average number of patients - 105)

[illegible]	
Head Nurses	5
Staff nurses	32
Students of Nursing	78
Pupil Nursing Assistants	6
Nursing Assistants and Aides	14
Orderlies	5
[illegible]	

(Daily average number of patients - 86)

[illegible]	
Head Nurses	1
Staff Nurses	26
Students of Nursing	45
Pupil Nursing Assistants	[illegible]
Nursing Assistants and Aides	23
Orderlies	3

Western Hospital, Alberton

(Daily average number of patients - 91)

Supervisors	-	1
Head Nurses	-	2
Staff Nurses	-	4
Nursing Assistants and Aides	-	8

King's County Memorial Hospital, Montague

(Daily average number of patients	-	23
Supervisors	-	1
Staff Nurses	-	10
Nursing Assistants	-	6

Stewart Memorial Health Centre, Tyne Valley

(Daily average number of patients	-	7)
Staff Nurses	-	3
Nursing Assistants	-	1

Chronic Care Unit, Prince County Hospital

(Daily average number of patients	-	16)
Supervisors	-	1
Staff Nurses	-	4
Nursing Assistants	-	11
Orderly (Part-time)	-	1

Community Hospital, O'Leary

(Daily average number of patients	-	18)
Supervisors	-	1
Head Nurses	-	3
General Duty	-	2
Nursing Assistants	-	5

Souris Hospital, Souris

(Daily average number of patients	-	8)
Supervisors	-	1
Staff Nurses	-	4
Nursing Assistants	-	5

Supervisors - 1

Head Nurses - 2

Staff Nurses - 4

Nursing Assistants and Aides - 8

(Daily average number of patients - 23

Supervisors - 1

Staff Nurses - 10

Nursing Assistants - 6

Stewart Memorial Health Centre, Tyne Valley

(Daily average number of patients - 7)

Nursing Assistants - 1

(Daily average number of patients - 14)

Supervisors - 1

Staff Nurses - 4

Nursing Assistants - 11

Orderly (Part-time) - 1

Community Hospital, O'Leary

(Daily average number of patients - 18)

Supervisors - 1

Head Nurses - 3

General Duty - 2

Nursing Assistants - 5

(Daily average number of patients - 21

Supervisors - 1

Staff Nurses - 4

Hospitals for Specialized Care

Tuberculosis Sanatorium, Charlottetown

(Daily average number of patients - 67)

Supervisors	- 1
Head Nurses	- 6
Staff Nurses	- 4 (1 part-time)
Licensed Nursing Assistants	- 11
Ward Aides	- 1
Orderlies	- 7

Rehabilitation Centre, Charlottetown

(Daily average number of patients - 19)

Supervisors	- 1
Staff Nurses	- 8
Nursing Assistants	- 7
Orderlies	- 4

Riverside Hospital, Charlottetown

(Daily average number of patients - 297)

Supervisors	- 5 (1 part-time)
Head Nurses	- 2
Staff Nurses	- 12
Psychiatric Nurse	- 1
Nursing Assistants	- 25
Students of Nursing	- 15
Pupil Nursing Assistants	- 6
Nursing Aides	- 7
Attendants	- 38

Nurses Employed in the Community

Public Health Nurses - 15

(Daily average number of patients - 67)

Supervisors - 1

Head Nurses - 6

(1 part-time)

Licensed Nursing Assistants - 11

Orderlies - 7

(Daily average number of patients - 19)

Supervisors - 1

Staff Nurses - 2

Nursing Assistants - 7

Orderlies - 4

Riverside Hospital, Charlottetown

(Daily average number of patients - 297)

Supervisors -

Head Nurses

Staff Nurses

Students of Nursing

Nurses Employed in the Community

Public Health Nurses - 15

Geographic Distribution

Charlottetown	-	4
West Queen's	-	2 (1 part-time)
Mount Stewart	-	1
West King's	-	1
Montague	-	1
Crapaud	-	1
Summerside	-	3
O'Leary	-	1
Alberton	-	1

Nurses In Private Practice

Charlottetown	-	23
Summerside	-	10

Nursing Service - Hospitals

A position description survey completed in January 1961 in non-governmental hospitals of Prince Edward Island by the Nursing Advisory Committee to the Hospital Services Commission and sponsored by it, revealed that nursing personnel ostensibly employed to provide direct patient care in hospitals are in fact performing many functions which normally fall to other personnel in hospital settings where adequate numbers of such personnel are available. A listing of such functions follows:

1. Laboratory Technicians
2. Dietitians
3. Internes (medical)
4. Social Workers
5. Orderlies
6. Ward Maids
7. Ward Secretaries

Charlottetown	-	4
Mount Stewart	-	1
West King's	-	1
Montague	-	1
Crapaud	-	1
O'Leary	-	1
Alberton	-	1

Nurses In Private Practice

Charlottetown	-	23
Summerside	-	10

A position description survey completed in January 1961 in non-governmental hospitals of Prince Edward Island by the Nursing Advisory Committee to the Hospital Services Commission and sponsored by it, revealed that nursing personnel actually employed to provide direct patient care in hospitals are in fact performing many functions which normally fall to other personnel in hospital settings where adequate numbers of such personnel are available. A listing of such functions follows:

1. Laboratory Technicians
2. Dietitians
3. Interns (medical)
4. Social Workers
5. Orderlies
6. Ward Helps
7. Ward Secretaries

In this connection it would appear that the use of any specific formula of nursing care hours per patient per day for budgetary purposes, which might reasonably apply in other provinces, is unrealistic in our present situation on the Island. The Hospital Services Commission is promoting a study of this problem and the members concur with the opinion of the Nursing Advisory Committee that the logical people to assess these needs are competent nurses working in the individual nursing service units under the supervision of the directors of nursing. Authorization has been given for nurse consultative assistance from the National Department of Health and Welfare to give further guidance in the conduction of this study.

Division of Public Health Nursing

The Director and fourteen public health nurses carry out a generalized service which does not include bedside nursing in the community. There are no occupational health nurses nor are there any visiting nurses. An educational programme including individual and group teaching is carried out in the areas of maternal and child health, school, communicable disease, tuberculosis and other areas as the need arises.

Recommendations

That investigation be made regarding the need for the following services;

1. Home Care, including geriatric nursing
2. Provincial Consultant in nutrition
3. Homemaker Services
4. A Consultant in Health Education for

present situation on the Island. The Hospital Services Commission is promoting a study of this problem and the members concur with the opinion of the Nursing Advisory Committee that the logical people to assess these needs are competent nurses working in the individual nursing service units under the supervision of the directors of nursing.

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Recommendations

That investigation be made regarding the need for the following services:

1. Occupational Consultant in nursing

2. [illegible]

4. A Consultant in Health Education for

the Province

Nursing Education

There are three hospital-conducted schools of nursing and one affiliate school which provides a twelve week affiliation in psychiatric nursing. All nursing education programmes for nurses are three years in length and all have been in existence for over 40 years.

In 1960 a Central School for Nursing Assistants was opened in connection with which a one year programme is being conducted. Pupils spend four months at this school and then are assigned to clinical experience at the hospitals which are conducting programmes for nurse education.

In the past ten years an average of 52 nurses were graduated annually from our schools of nursing. A total of 26 pupils were graduated from the Central School for Nursing Assistants in 1961. The current enrolment in all schools is indicated below:

Charlottetown Hospital School of Nursing	-	83
Prince Edward Island Hospital School of Nursing	-	63
Prince County Hospital School of Nursing	-	54
Central School for Nursing Assistants	-	35

In view of the fact that our nursing schools are engaged in evaluating their programmes in connection with the Canadian Nurses' Association School Improvement Programme, we will not include recommendations on Nursing Education at this time. We are aware, however, of the following problem areas:

be Province

Nursing Education

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Nursing	- 8[illegible]
School of Nursing	- 6[illegible]
Prince County Hospital School of Nursing	- [illegible]

In view of the fact that our nursing schools are engaged in evaluating their programmes in connection with the [illegible] Curriculum Council improvement Programme, we will not include recommendations on Nursing Education at this time. We are aware, however, of the following problem areas:

1. Lack of a sufficient number of qualified instructors, both for science and clinical instruction.

2. Limited clinical experience in the area of pediatric nursing.

3. Difficulty in retaining faculty.

4. Lack of adequate library and laboratory facilities.

5. Limits are set on the education experience of students because they provide nursing service to such a degree in hospitals.

Conclusion

We are anticipating a national programme of accrediation for schools of nursing and are eager to participate in this and prepare for it. We firmly believe that it is only through enriching our educational programmes and improving the practice field where students are learning to nurse, that our people will receive the type of care they deserve in hospitals and in the community.

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3. [illegible]

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THE CHAIRMAN: Thank you. Have you anything further you may wish to add by way of observation or explanation at this time?

MISS MacKAY: Other than we are aware of some of our needs, but with the various studies that are being conducted we don't feel prepared to supply any solution for it at the moment. We hope to have an opportunity later to produce something.

THE CHAIRMAN: That opportunity will always be open to your organization within the time, of course, that the Commission is working.

You say that you are conducting a local study on requirements. Are you able to say when that might be available?

MRS. BOLGER: In connection with the Hospital Services Commission, the Nursing Advisory Committee has begun a study -- I think it began in one hospital this fall -- in a 20-bed unit, and we hope that the nurses working in the individual hospitals will conduct a study. But we hope that they will have guidance from the National Department of Health and Welfare. We have made a request that a consultant, who has been appointed recently, may come and assist us. We don't know when it will be available. If you wish to have the findings we are prepared to submit them at that time.

THE CHAIRMAN: When they are available.

MRS. BOLGER: Yes.

COMMISSIONER GIRARD: Miss MacKay, although I realize that this is a statement and that you have

CHAIRMAN: Thank you. Have you anything further you may wish to add by way of [illegible]tion or explanation at this time?

[illegible]

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THE CHAIRMAN: When they are available.

MRS. BOLDER: Yes.

COMMISSIONER GIRARD: Miss Mackay, although

not yet come to the recommendations that you wish to make to the Commission, I would like to clarify certain statements, and one is that you name, you enumerate a certain number of factors influencing utilization of nursing personnel. This was brought out this morning also. I would like to know if the Association has thought through any formalized ideas as to better utilization of nursing personnel.

SISTER MARY IRENE: Mr. Chairman, we did carry out, as part of the function of the Advisory Committee to the Commission last year, a survey. Actually we did a job analysis of the nursing personnel in the different hospitals in the province, and we did find the nurses carrying out a tremendous number of functions other than nursing functions, and some of those are included in the list there, and we felt, of course, when they were doing them they were not giving the time they should be giving to the patient. We did compile a job description, and that job description was set out to all the hospitals and to the Commission, and I do think the position has improved considerably in some areas last year. I know the Commission accepted our recommendations. For example, dieticians. I stand to be corrected, but I believe there are only two dieticians working in hospitals in the province. There is another person who is an advisor but not really a dietician. So therefore the nurses must assume a great deal of this responsibility. The lab technicians find themselves doing a lot of

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additional work because the number is not great enough to do the work, and so on down the line. I think in some areas it has improved, and certainly in the area of ward work. I think perhaps because of our survey last year and recommendations that that has been improved somewhat in hospitals where the nurses did so much dusting and cleaning.

THE CHAIRMAN: Thank you Sister Mary Irene.

COMMISSIONER GIRARD: Miss MacKay, in recommendation No. 1 you speak of home care. Is this organized home care or bedside nursing care?

MRS. BOLGER: May I direct that to Mrs. La Flair?

MRS. LA FLAIR: In particular, regarding the home care situation, it has been suggested and we know that in the Division of Public Health Nursing which carries on a very comprehensive generalized piece of work throughout the province there are nine different public health sections where one public health nurse in the rural areas, three in Summerside, four in Charlottetown carry out a generalized program of public health nursing. This includes home visiting for educational purposes. They do the maternal visiting; they are also doing follow-up for tuberculosis, and in some cases for mental health where there are home conditions to be told. For instance, in rural areas there will be one nurse. They have their own office; they are entirely responsible for all the community and the surrounding area. They are responsible for the school, for the

work because the number is not great [illegible] work, and to do some [illegible]. I think in some areas it has improved, and certainly in the area of ward work. I think perhaps because of our survey last year and recommendations that that has been improved somewhat in hospitals where the nurses did so much dusting and cleaning.

COMMISSIONER GIRARD: Miss Mackay, in recommendation No. 1 you speak of home care. Is this [illegible]

MRS. HOLDER: May I direct this to Mrs. La Plain?

MRS. LA PLAIN: In particular, regarding the home care situation, it has been suggested and we know that the Division of Public Health Nursing which carries on a very comprehensive generalized piece of work throughout the province there are nine [illegible] health nurse in the rural areas, three in Summerside, four in Charlottetown carry out a generalized program of public health nursing. This includes home visiting for educational purposes. They do the maternal visiting; they are also doing follow-up for tuberculosis, and in some cases for mental health where there are home conditions to be told. For instance, in rural areas there will be one nurse. They have their own office; they are entirely responsible for all the community and the surrounding area. They are responsible for the school, for the

immunization; the nurse will visit the school or do the follow-up visits. Anything concerning the health of that community is hers. So you will see it is well organized.

When I say that there is no bedside care included in this, it is not generally included in the work of the official agency nurses. However, it would appear there might be need for organized bedside nursing care in the community, and I am not basing this on any study, because none has been done to my knowledge. We would be willing to cooperate in any way should a study be considered necessary, and I would think from my own personal point of view that it would be necessary to establish the fact perhaps by having a public health nurse or someone qualified to do this work estimate or evaluate the need for bedside care in the community by contacting the private physicians, by talking to the hospital personnel, by following up to see how much bedside care is required. If they are going to be sent home earlier from hospital this might be a consideration.

From isolated comments it would appear that there are older people in the community who are need of bedside care. This I do not know. Also, that there would be need perhaps even more urgently for homemaker services. There is no one to see to an old lady with a broken leg; she is all by herself, depending on neighbours coming in; no one to buy her groceries, such simple things like this, and so on. I am simply saying that this is not in the

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work that is being done in our public health agency. I am not suggesting it should be. I would suggest that if this is taken into consideration there might be four ways of carrying out this work in the community.

One would be from the hospital, perhaps going out from hospital to do this type of work, bedside care. They would be perhaps in the best position to know whether the patient required the care.

Another way of doing it would be to take on additional nurses in our official health agency to do this type of work, under the same administration which now exists. It would require a great deal of thinking and one which we would be willing to consider doing should this be the decision of the Nursing Association.

Another plan is to have visiting nurses doing hourly nursing, perhaps from the Registry of Nursing Association. This I have not discussed with anybody particularly, but I understand this type of bedside care is done sometimes on a visiting nursing hourly basis, they pay by the hour.

Then a fourth way would be to ask the voluntary agency to come in and put on a demonstration and determine the amount of need. But first of all this need would have to be established. Thank you.

COMMISSIONER GIRARD: Mrs. La Flair, the survey that was made, if you were to include it in

be four ways of carrying out this work in the [illegible]

One would be from the hospital, perhaps going out from hospital to do this type of work, bedside care. They would be perhaps in the best position to know whether the patient required the [illegible]

Another way of doing it would be to take on additional nurses in our official health agency to do this type of work, under the same administration which now exists. It would require a great deal of thinking and one which we would be willing to consider doing should this be the decision of the Nursing Association.

Another plan is to have visiting nurses doing hourly nursing, perhaps from the Registry of Nursing Association. This I have not discussed with anybody particularly, but I understand this type of bedside care is done sometimes on a visiting nursing hourly basis, they pay by the hour.

Then a fourth way would be to ask the voluntary agency to come in and pit on a demonstration and determine the amount of need. But first of all this need would have to be established. Thank you.

COMMISSIONER GIRARD: Mrs. La Plant, the [illegible]

forthcoming brief of the Association of Nurses of Prince Edward Island to the Commission it would be very helpful to us.

MRS. La FLAIR: Yes, we would certainly do that.

COMMISSIONER GIRARD: One more question. You stated on page 8 that you have 52 nurses graduating annually from three schools. This gives a number of 14 per school. Do you have any difficulty in recruiting or is this a normal number for the facilities which you have in your schools?

MRS. BOLGER: Mr. Chairman, recently we haven't had difficulty in recruiting; we find that there is more choice of candidates than there were previously. We do have a program or a vocational guidance program under the Association of Nurses, but it hasn't been as active in the last couple of years because we haven't found that phase necessary.

THE CHAIRMAN: What is the capacity for student nurses in these three hospitals?

MRS. BOLGER: Mr. Chairman, we have found that in the larger hospitals in Charlottetown, Charlottetown School of Nursing and the Prince Edward School of Nursing, the capacity is about 35. That is for three years. This is 25 in each class, and in the Prince Edward School of Nursing possibly 15 in each class, for a total of 45 for three years. That is according to the facilities which we have.

COMMISSIONER GIRARD: Mrs. Bolger, there is one more point I had marked down. Difficulty

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MRS. LA FLAIR: Yes, we would certainly do that.

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MRS. GOURLEY: Mr. Chairman, we have found that in the larger hospitals in Charlottetown, Charlottetown School of Nursing and the Prince Edward School of Nursing, the capacity is about 25. That is for three years. This is 25 in each class, and in the Prince Edward School of Nursing possibly 15 in each class, for a total of 45 for three years. That is according to the facilities which we have.

retaining staff, No. 3, on page 8. Can you give us any other factors that are responsible for this?

MRS. BOLGER: Well, possibly someone else working in the hospitals might answer that better than I could. But there are, as in other places, many factors which influence this. The heavy teaching load; I am thinking of teaching personnel. Also the fact that there is no university centre here where the nurses can continue their studies. Possibly salary; some opportunities that are better in other areas. But there are a great number of factors involved. Possibly Mrs. La Flair could speak further to that.

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teaching load; I am thinking of teaching personnel. Also the fact that there is no university centre here where the nurses can continue their studies. Possibly salary; more opportunities that are better in other areas. But there are a great number of factors involved. Possibly Mrs. La Fleur could speak further to that.

THE CHAIRMAN: Have the nursing schools of Prince Edward Island given any thought to a centralized teaching program in the first six months of the course, so as to better utilize the instructional staff that is available in the basic subjects?

MRS. BOLGER: Yes, we have talked about it a number of different times, and we now, recently we have thought about it again, but as we are participating in the Canadian Nursing Association's School Improvement Program, we thought this was not the time to make a decision, and possibly we would have more expert guidance and could make a decision later. We have two colleges, a junior college and a college that grants a degree, and we thought we could probably utilize some of their utilities and teaching personnel before we have this change in our own personnel, and that has been considered, Mr. Chairman.

COMMISSIONER BALTZAN: Under whose auspices, or direction, are nurses' aides being trained, under the schools of nursing, or the Department of Health, or?

MRS. BOLGER: I think the Department of Health, sir.

COMMISSIONER BALTZAN: They have a program and a curriculum?

MRS. BOLGER: Yes.

COMMISSIONER VAN WART: Do you utilize the school at Moncton?

MISS MacKAY: No, they have a separate school

CHAIRMAN: Have the nursing schools of Edward Island given any thought to a centralized training program in the first six months of the course, so as to better utilize the instructional staff that is available in the basic subjects?

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COMMISSIONER SALTZMAN: Under whose auspices, or direction, are nurses' aides being trained, under the schools of nursing, or the Department of Health, say?

MRS. BOLDER: I think the Department of Health, sir.

COMMISSIONER SALTZMAN: They have a program and a curriculum?

COMMISSIONER VAN WART: Do you utilize the school at Moncton?

MISS MacKAY: No, they have a separate school

here set up.

COMMISSIONER VAN WART: Under the Department of Education?

MISS MacKAY: Under the Department of Health.

COMMISSIONER STRACHAN: Mr. Chairman, I have been wondering what the recognized or desirable proportion, what is the recognized or desirable proportion between the nurses and the nursing assistants?

MRS. BOLGER: Mr. Chairman, I don't know that that has been worked out. It depends on so many factors in the hospital, whether you have a larger number of acutely ill patients. Certainly the province of the nursing assistant is the care of the chronically ill, and of course they do assist with the care of the acutely ill, but it would depend on the degree of illness of the patient, and I am not prepared to say if there is any percentage, or whether there should be. That should be decided in the individual situation.

COMMISSIONER McCUTCHEON: One question was raised in my mind by your statement No. 5 on page 8, where you say:

> "Limits are set on the educational experience of students because they provide nursing service to such a degree in hospitals."

I turned to the establishment, and I notice that the total of supervisors, head nurses and staff nurses in the Prince Edward Island Hospital is 50, and there

COMMISSIONER VAN WART: Under the Department of Education?

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COMMISSIONER STRACHAN: Mr. Chairman, I have been wondering what the recognized or desirable proportion, what is the recognized or desirable proportion between the nurses and the nursing assistants?

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COMMISSIONER MOODYCHEWON: One question was raised in my mind by your statement No. 5 on page 6, where you say:

> "Limits are set on the educational experience of students because they provide nursing service to such a degree in hospitals."

I turned to the establishment, and I notice that the total of supervisors, head nurses and staff nurses in the Prince Edward Island Hospital is 50, and there

are 63 students. In the Charlottetown Hospital the corresponding number of staff is 48, and the number of students is 78. In Summerside it is 40 and 45. Is it a fair inference that the hospitals are relying unduly on student nurses, unduly making use of the so-called apprenticeship scheme for nursing services?

SISTER MARY IRENE: Speaking for our own situation, and I am not sure that I understand your question, but we find that our student body, perhaps it is a little bit larger for the size of the hospital, but we find that they are expected to give approximately half the nursing service, and that the other portion is made up of professional nurses and other personnel, but they give approximately half of the nursing hours, and I think it would be a little too much to work out an educational program. Perhaps, I know we are getting away considerably from the apprenticeship method, sir, but I am afraid there is a little bit of it still around.

COMMISSIONER FIRESTONE: Miss MacKay, I understand that your group is considering submitting to the Royal Commission a subsequent brief, which might contain second thoughts, or specific recommendations you may have. Could this brief contain recommendations as specific as possible to suggest concrete things that could be done in the development of a practical and realistic program of expanded nursing services in Prince Edward Island, what it would cost to do this, and how such a program could be financed?

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SISTER MARY LEWIS: Speaking for our own situation, and I am not sure that I understand your question, but we find that our student body, perhaps it is a little bit larger for the size of the hospital, but we find that they are expected to give approximately half the nursing service, and that the other portion is made up of professional nurses and other personnel, but they give approximately half of the nursing hours, and I think it would be a little too much to work out an educational program. Perhaps, I know we are getting away considerably from the apprenticeship method, sir, but I am afraid there is a little bit of it still around.

COMMISSIONER FINESTONE: Miss Mackay, I understand that your group is considering submitting to the Royal Commission a subsequent brief, which might contain second thoughts, or specific recommendations you may have. Could this brief contain recommendations as specific as possible to suggest concrete things that could be done in the development of a practical and realistic program of expanded nursing services in Prince Edward Island, what it would cost to do this,

MISS MacKAY: We shall do that.

THE CHAIRMAN: Thank you very much, Miss MacKay.

THE SECRETARY: That submission will be known as Exhibit 32.

EXHIBIT NO. 32: Submission of the Association of Nurses of Prince Edward Island.

THE CHAIRMAN: The next is a statement by the Prince Edward Island Pharmaceutical Association. This will be No. 33.

EXHIBIT NO. 33: Submission of the Prince Edward Island Pharmaceutical Association.

SUBMISSION OF THE PRINCE EDWARD ISLAND PHARMACEUTIAL ASSOCIATION

APPEARANCES: J. Watson MacNaught

MR. MacNAUGHT: Mr. Chairman, and members of the Royal Commission on Health Services, this is a very short and precise statement, prepared by the Pharmaceutical Association of Prince Edward Island. Possibly the most expeditious way is to read the resolutions passed at a meeting of the Association.

At a meeting of the council of the Prince Edward Island Pharmaceutical Association it was unanimously resolved as follows:

RESOLVED that the Prince Edward Island Pharmaceutical Association endorse and approve the

MISS MacKAY: We shall do that.

THE CHAIRMAN: Thank you very much, Miss MacKay.

THE SECRETARY: That submission will be known as Exhibit 32.

EXHIBIT NO. 32: Submission of the Association of Nurses of Prince Edward Island.

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At a meeting of the council of the Prince Edward Island Pharmaceutical Association it was unanimously resolved as follows:

WHEREAS the Prince Edward Island Pharmaceutical Association endorses and approve the

brief of the Canadian Pharmaceutical Association which will be submitted to the Commission for its consideration.

RESOLVED FURTHER that the Prince Edward Island Pharmaceutical Association reserve the right to submit a supplemental and/or rebuttal brief or briefs at the meeting of the Commission to be held in Ottawa in June should the Association deem it necessary.

All of which is respectfully submitted.

Dated this 13th day of October, A.D. 1961.

THE CHAIRMAN: Your statement about a meeting in June will be on a date to be --

MR. MacNAUGHT: Oh yes. I understand that, naturally.

THE CHAIRMAN: That concludes the list of those organizations which we said we would hear today. We will adjourn until 10:00 o'clock tomorrow morning.

---Whereupon the hearing was adjourned until 10:00 a.m., Wednesday, 8th November, 1961.

which will be submitted to the Commission for its consideration.

Island Pharmaceutical Association reserve the right to submit a supplemental and/or rebuttal brief or briefs at the meeting of the Commission to be held in Ottawa in June should the Association deem it necessary.

All of which is respectfully submitted.

Dated this 13th day of October, A.D. 1961.

THE CHAIRMAN: Your statement about a meeting in June will be on a date to be --

MR. MACNAUGHT: Oh yes. I understand that, absolutely.

THE CHAIRMAN: That concludes the list of those organizations which we said we would hear today.

---Whereupon the hearing was adjourned until 10:00 a.m. Wednesday, 25th November, 1961.